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The Massachusetts Medical Society

THE FRACTURE EXHIBIT AT THE ANNUAL MEETING OF THE MASSACHUSETTS MEDICAL SOCIETY AT SPRINGFIELD, MASS., JUNE, 1926

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Committee on Fracture Exhibit

It is significant of the growing importance of the subject of traumatic surgery that the President of the State Society of Medicine in Massachusetts should have secured the appointment of a Committee to prepare an educational exhibit on fractures. The Committee felt that the exhibit should be simple and practical. The minimum splint and apparatus requirement for the initial or emergency treatment of fractures suggested by the American College of Surgeons was used as the basis of the exhibit. The exhibit consisted of five parts. Photographs of various parts of the exhibit were taken and cuts of them are used to illustrate this report.

1. The emergency use of the Thomas Splint for the lower extremity:

A living model, with a supposed fracture of the leg, was shown on an improvised stretcher. A Thomas Splint had been applied and traction was secured through a hitch over the shoe and a windlass, with counter traction through the splint-upright to the ring. This demonstrated the use of the splint for transportation.

2. The use of the Thomas Splint for bed traction as a permanent method of treating fracture of the femur.

A hospital bed was carefully made up by an attending nurse. A living model dressed in tights with a supposed fracture of the femoral shaft was put up in skin traction. The traction force acted over a pulley at the foot of the bed. The limb was suspended from a Balkan Frame through the medium of a Thomas Splint. The various advantages of this apparatus were stated by an attendant. On a small table were printed slips picturing the Balkan Frame in use and stating the necessary measurements for the making of the Thomas Splint. These slips were given each visitor to the Exhibit.

A simple U. S. Army Balkan Frame, as carefully worked out by Col. William Keller, Surgeon to the Walter Reed Hospital, Washington, D. C., was shown in the original package. This was a duplicate of the frame set up over the bed.

3. The necessity for Roentgenological records of fractures was stressed. That these X-Rays must be taken in two planes was illustrated.

4. Colles' Fracture was the only special fracture considered. Drawings and X-Rays were shown. The necessity for complete reduction under an anaesthetic was emphasized.

5. A complete assembling of all the simple materials for the initial treatment of fractures of the long bones was made:—pieces of splint wood, sheet wadding, cotton bandages, plaster of paris bandages, adhesive plaster, Murray hinged arm splint, Thomas leg splint for adult and for child, Cabot posterior wire splint. The simplicity of this outfit was most apparent to all and this very simplicity was so emphasized that it actually became an occasion for criticism of the whole Exhibit. This is exactly what the Committee in charge hoped for, an impression that the early treatment of a fracture is not only most important but that the adequate equipment for this early treatment is very simple.

The Committee believes that by such demonstrations conducted at the annual meetings of every State Medical Society, considerable progress may be made toward informing the general practitioner and surgeon of the accepted and simple methods of treating fractures.

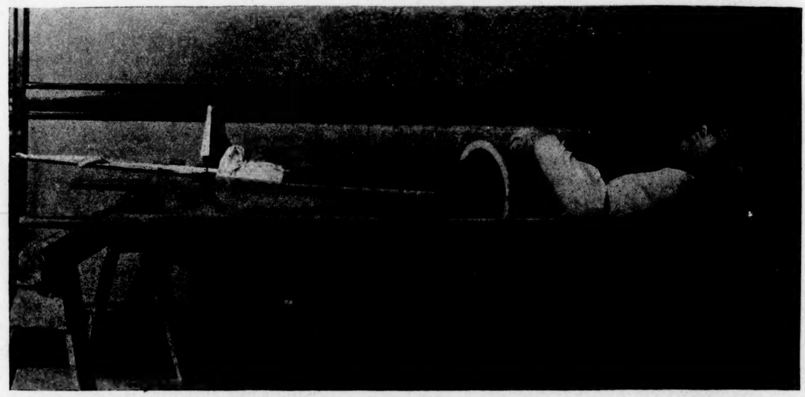
The Committee believes that the treatment of fractures should be as simple as is possible.

The Committee believes that the treatment of fractures can never be standardized, because the conditions attending such injuries are too varied.

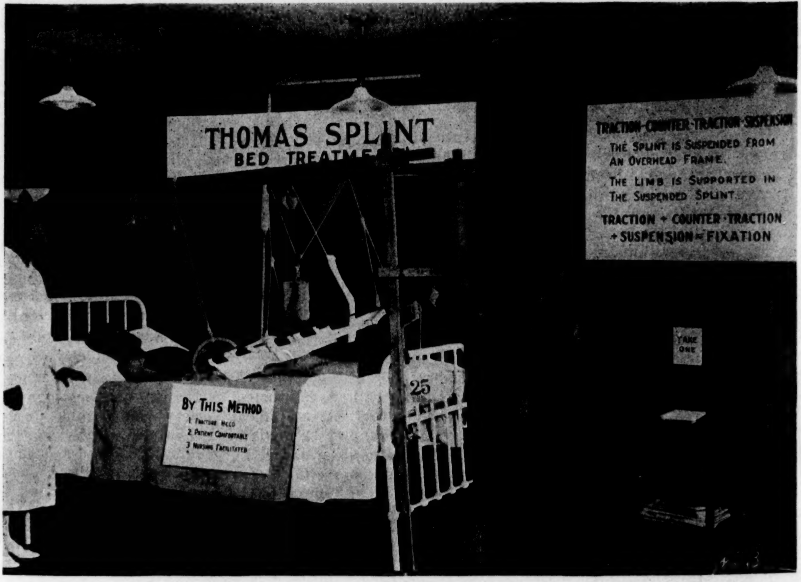
(BOOTH ONE)

THOMAS SPLINT

FIRST AID & TRANSPORTATION



(BOOTH TWO)


THOMAS SPLINT
BED TREATME
TRACTION-COUNTER-TRACTION-SUSPENSION
THE SPLINT IS SUSPENDED FROM AN OVERHEAD FRAME.
THE LIMB IS SUPPORTED IN THE SUSPENDED SPLINT.
TRACTION + COUNTER-TRACTION + SUSPENSION = FIXATION
BY THIS METHOD
1. FRACTURE HEALED
2. PATIENT COMFORTABLE
3. NURSING FACILITATED
25
TAKE ONE

(BOOTH THREE)

X-RAY

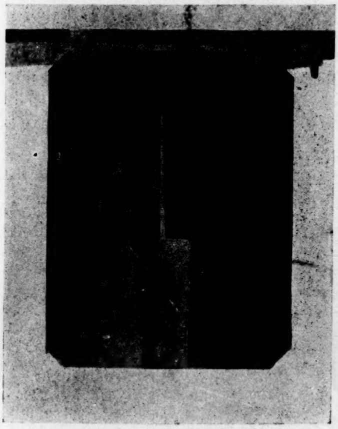
TWO VIEWS ALWAYS

EVERY FRACTURE SHOULD BE X-RAYED

YOU NEED IT
COURTS DEMAND IT
INSURANCE COMPANIES INSIST ON IT
COMMON SENSE URGES IT
IT SAFEGUARDS THE PATIENT

ANTERO-POSTERIOR VIEW **LATERAL VIEW**

SPLENDID! **"ROTTEN"!**



(BOOTH FOUR)

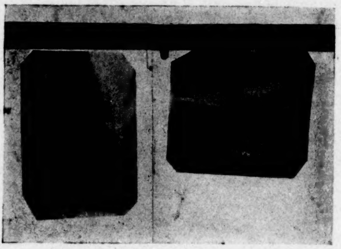
COLLES' FRACTURE

CAN THIS FRACTURE BE REDUCED
USUALLY AND SATISFACTORILY
WITHOUT AN ANAESTHETIC?

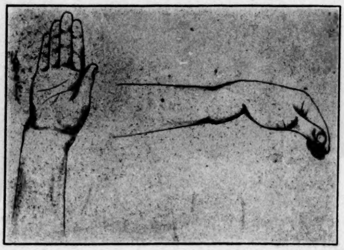
MOST PAINFUL WRISTS FOLLOWING
COLLES' FRACTURE
INDICATE INCOMPLETE REDUCTION.

X-RAY OF COLLES' FRACTURE

ANTERO-POSTERIOR VIEW **LATERAL VIEW**



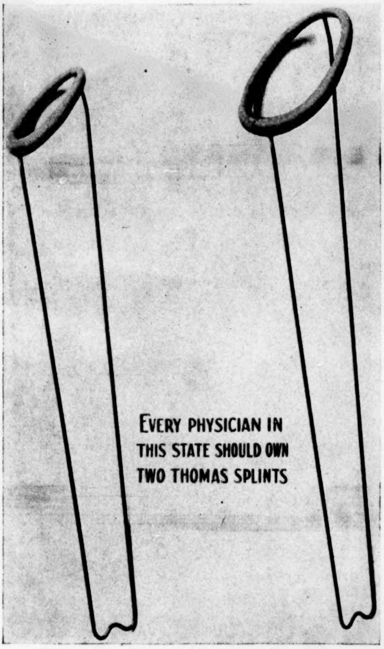
TYPICAL SILVER FORK DEFORMITY

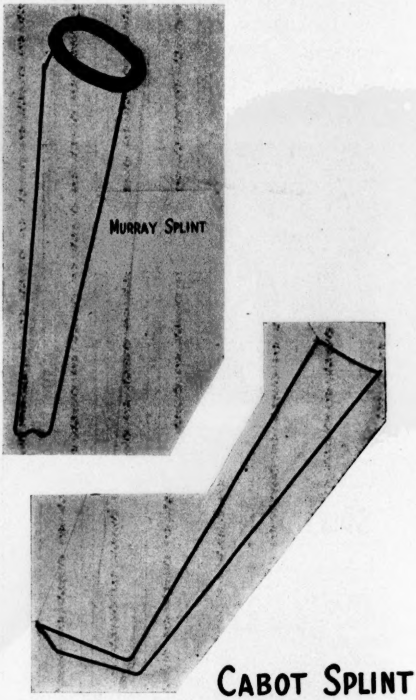


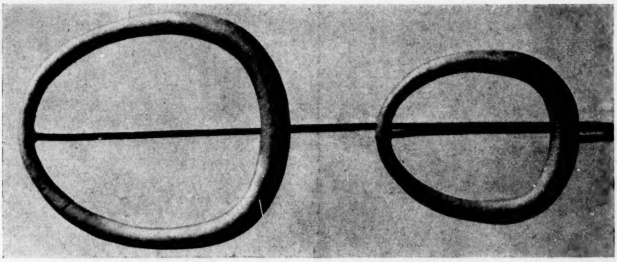
(BOOTH FIVE)

EQUIPMENT FOR THE EMERGENCY TREATMENT OF MOST FRACTURES

NOTE: Other equipment such as splint wood, sheet wadding, cotton bandages, plaster of Paris bandages, adhesive plaster, etc., appeared on another wall of the exhibit and is not here shown.







Illustrating the shape and padding of the rings of Thomas splints of adult and child size.

ORIGINAL ARTICLES

HEALTH EXAMINATIONS*

BY ROGER I. LEE, M.D.

THE subject of health examinations has occupied a prominent place in medical and lay discussions in the last few years. There seems to be a reasonable unanimity of opinion in regard to the general desirability of health examinations and the importance of these examinations as a public health measure. Nevertheless the technique of these examinations has been worked out in connection with rather restricted groups and each group has its own particular problem. The solution of the problems of health examinations in any particular group has not seemed to have helped directly in the solution of the technical difficulties of the health examination in general practice. For example the physical examination of school children has often meant merely inspection and not a physical examination in the accepted medical sense. To be sure usually the eyes, teeth and throat are examined, but often the clothing is not removed and often there is no examination of the urine. Sometimes the schedule calls for the examination of one child every two or three minutes by a given examiner. There is a good deal to be said in favor of such an inspection but such an inspection is not a health examination. The same comment may be made of some of the medical inspections in industries where the sole object of the examination is the elimination of the unfit. There should of course be no real confusion between such inspections or examinations for the purposes of eliminating unfit, and the health examinations. However, this confusion does exist in the minds of the physicians, those examined and the laity. The life insurance companies, which formerly utilized the physical examination solely for the purpose of eliminating poor risks, have been greatly enlarging the scope of their physical examinations. Some of the life insurance companies are employing what amounts to periodic health examinations in form and spirit for the benefit of their clients. Some years ago an organization was formed to attempt to solve the technical difficulties of health examinations. This organization, the Life Extension Institute, has been active in promoting public interest in health examinations and in carrying out one form of health examination. The medical profession in the meantime became active. Queen's County Medical Society, which includes Brooklyn, N. Y., did pioneer work in health examinations. The American Medical Association has gotten out a pamphlet and a form for physical examinations. Various of the state and county societies have followed suit. A Committee of the Massachusetts Medical Society made a very careful study of the problem of health examinations. The committee, of which I had the honor to be Chairman, summarized its findings under the following nine points:

1. A permanent record.
2. Ample time for the examination.
3. A careful study of the individual case.
4. Examination of the patient without clothing.
5. A thorough review of the findings of the history and physical examination.
6. Careful and explicit advice to each individual patient, with adequate appreciation that organic soundness is often associated with marked functional disturbances.
7. Utilization of the interview after the physical examination for the instruction in the simple rules of hygiene.
8. Encouragement to the patient to report periodically for reëxamination, ordinarily at the end of a year, and always at the onset of striking symptoms, particularly losses or gains of weight, persistent cough, etc.
9. Adequate remuneration for services.

The Committee furthermore presented a form which was much simpler than the form of the American Medical Association and which the Committee regarded as a basic minimum. The Committee held to the belief that the health examinations should be carried out by the general practitioner. The Committee endeavored to secure a form which the busy general practitioner would find feasible. Frankly the Committee did not feel that this form was probably the best form that could be devised for health examinations; it merely felt that this form was the best form that it could devise for the introduction of health examinations into the medical profession of the state of Massachusetts. The Standing Committee on Public Health of the Massachusetts Medical Society with the view of further acquainting the medical profession with health examinations arranged with Dr. Joseph Garland to prepare a small hand-book on the subject of health examinations. This hand-book was printed in the BOSTON MEDICAL AND SURGICAL JOURNAL and was circulated to all members of the Medical Society in reprint form.

My own experience with health examinations began some 12 years ago with the students of Harvard College. Investigation at that time showed that the so-called normal individual had received very little attention from the medical profession in general. It was rather amazing to find that essentially there were no standards of so-called normality. We had to establish our own standards. We had to interpret for ourselves the significance of variations of blood pressure, the significance of systolic murmurs, the significance of small amount of albumin or sugar in the urine. Since that time abundant data have become available concerning apparently normal people. It is of course necessary for persons carrying out health examinations to become acquainted with the normal variations of

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*Read before the Suffolk District Medical Society, March 31, 1926.

PERIODIC HEALTH EXAMINATION

PREPARED AND PUBLISHED BY THE
American Medical Association, 535 North Dearborn Street, Chicago, Illinois

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Form A **HISTORY FORM**

Use check mark (√) in making affirmative answer to questions wherever possible.

1. **Name** **Country of Birth**

2. **Address** **White** **Colored**

3. **Age** Religion **Single** **Married** **Widowed** **Divorced**

4. **What is your present occupation**

5. Have you changed your work frequently Why

6. **What are the conditions of your work**
   Regular
   Satisfactory
   Monotonous
   Dangerous
   Fatiguing
   Indoors Out
   Dark
   Light
   Dusty
   Smelly
   Noisy
   Crowded
   Seated
   Standing
   Walking
   Hours per day
   Days per week

7. Are your earnings sufficient to support yourself and dependents comfortably

8. **What are your home conditions**
   In a family
   Alone
   Congenial
   Depressing
   Quiet
   Irritating
   Room and bed to yourself
   Time to yourself

9. **What are your sleeping conditions**
   Hours in bed
   Windows open
   Restful
   Disturbed

10. **How often do you eat**
    Regularly
    Where
    Between meals
    Time of meals

11. **Are you a moderate or hearty eater,** taking one or more helpings at a meal of
    Meat (including fish and eggs)
    Baked beans
    Green vegetables (spinach, cabbage, etc.)
    Potatoes (rice, macaroni or cereal)
    Pie, Cake or Pastry
    Sweets or Sugar
    Fruits
    Salads
    Bread
    Butter

12. **How much do you drink daily of**
    Milk
    Water
    Tea
    Coffee
    Soft drinks
    Alcoholic drinks

13. How frequently do you use candy How much tobacco

14. **Do you have a movement of the bowels daily** With the use of drugs

15. What exercise do you take in addition to your work

16. What are your social, religious, political, club or trade associations

17. What are your pleasures Recreations Hobbies

18. **Are you subject to worries** **Moods** **Periods of alternating gloom and cheerfulness**

19. **Have you ever been ill with any of the following, or any other severe illness and at what ages**
    Tuberculosis
    Malaria
    Rheumatism
    Syphilis or Gonorrhea
    Scarlet Fever
    Diphtheria
    Typhoid Fever
    Tonsillitis (Sore Throat)
    Frequent Colds
    Convulsive seizures
    Nervous Breakdown
    Migraine or Neuralgia

20. **Have you been protected against small pox typhoid diphtheria or other diseases by vaccination and when**

21. Have you had any accidents, broken bones or surgical operations

22. How often do you consult your dentist When last

23. **Are your parents, brothers and sisters living**
    If not what were the causes of death and at what ages

24. Have either of your parents or any brother or sister had consumption cancer
    Insanity epilepsy gout diabetes

25. **Do you consider yourself in good health** If not, what is your complaint

For Women

26. **Are your monthly periods regular** Prolonged Excessive

27. **Have they interferred with your occupation** In what way

28. **Have pregnancies and confinements been free from accident**

physical findings. To my mind the value of health examination in groups lies in the furnishing of statistical experiences which can be used by other groups and more particularly by the general practitioner, who functions as an individual.

Form B **PHYSICAL EXAMINATION RECORD**

Name		Case No.	Date
1. Height	Weight, Present Usual Standard (for age and height)	Pulse	Bl. Pres. { Sys Dias.
Hearing R L	Vision R L		Corrected R L
Urine: appearance	Sp. Gr.	Alb.	Sugar
Feces (when indicated): appearance		Blood	Parasites

Record only abnormal conditions

2. Standing
Posture
Musculature
Nutrition
Skin
Superficial Glands
Female Breast
Hands
Arms
Male Genitalia
Hernia
Legs
Feet
Romberg sign

3. Sitting
Hair
Eye reflexes
Nose
Teeth
Gums
Tongue
Tonsils
Pharynx
Ears
Chest
Heart
Lungs
Visceral Ptoses

4. Lying down
Abdomen
Reflexes
Sensation
Liver
Spleen
Kidneys
Prostate Gland
Female genitalia
Rectum (hemorrhoids)

5. Summary: Defects of function and structure and errors of habit.

6. Advice given to the patient:

About two years ago, after leaving the University, I was asked if I would undertake the organization of health examinations for a business concern employing over 1000 employees. This firm recognized the importance of health examinations and was willing to offer such a service to its employees in the hope that the employees might subsequently decide to have this physical examination carried out by their family physician. The firm, furthermore, did not require any of its employees to submit to this examination. 856 availed themselves of this examination. In every instance where possible the name of the family physician was obtained and in every instance when the employee requested it the findings were sent to the family physician. Only 145 requested that the findings be sent to the family physician. It is worthy of note that

PHYSICAL EXAMINATION RECORD

HISTORY

Name Address
Date Occupation
Family History
Social and Marital History
Previous History
Habits
Recreations
Accidents
Operations
Special Data for Women
Present Status

PHYSICAL EXAMINATION

With With
Age: Yrs. Mos. Height: Without shoes Weight: Without clothes
Color General Appearance
Posture Feet Shoes
Eyes: R L Glasses: R L When examined
Mouth
Throat
Nose
Ears Hearing
Heart
Pulse rate B. P.
Lungs
Abdomen
Hernia Genitalia Hemorrhoids
Varicose veins Glands
Urine: Color Sp. gr. Reaction Alb. Sug. Sediment
Hgb. Wassermann reaction
Summary
Advice

HARVARD UNIVERSITY

DEPARTMENT OF HYGIENE

Full name of student..........
Class..........Age..........yrs. ....mos. Date of examination..........

FAMILY HISTORY

F., born in..........,..........
M., born in..........,..........
....
....

PAST HISTORY

Underline and give approximate age at which student had any of the diseases listed in the square:

What injuries, with dates? ....
What operations, with dates? ....
Present general health..........Appetite..........Sleep..........hrs.
Has done..........; also..........
Is doing outside remunerative work.......... hrs. per week
Usual recreation previously.......... hrs. per week
" " now .... " " "
Can..........swim 50 yards.
Dates of successful vaccinations.......... Failures..........
Dates of Typhoid vaccination ....
Cups tea average..........per.......... Cigarettes average ....per..........
Cups coffee " .... " .... Pipes " .... " ....
Cigars " .... " ....

Measles
Pertussis
Mumps
Chicken-pox
Scarlet Fever
Typhoid Fever
Diphtheria
Malaria
Smallpox
Pneumonia
Pleurisy
Rheumatism
Tonsillitis
Influenza
Otitis Media
Gonorrhea
Syphilis
Constipation
Chorea
Convulsions

PHYSICAL EXAMINATION

Color..........Apparent Age..........Peculiarities..........
Eyes: Right..........Left.......... Corrected to: Right..........Left..........
Wears glasses, constantly, reading, distance, when obtained.......... Needs to see oculist. Color-vision = ...
Hearing: good, fair, poor. Needs aurist..........
Gen. Devl.: excel., av., poor. *N.:* thin, av., obese. *Skin:*..........
Scars ....
Acne: Face.........., Chest.........., Back..........
Skeletal Type..........
Distribution of fat and hair ....
Chest: cir. at xiphoid { Exp..........in. / Neu..........in. / Ins. ....in.
Shoulders: norm., round. *Scapula:* norm., scaphoid.
Chest: norm., flat, funnel, pigeon, flaring at base.
Vert. Col.: norm. Lordosis:.......... Scoliosis:..........dors.......... ....lumb..........
Weight:..........lbs. *Height:*.......... *Pup.:* R. L. re. to l. and d. Size:.......... Dance.
Teeth: good, av., poor, neglected, false. *Thyroid:* norm., sl. enlarged.
Nose: obstruction R. L. nostril ....Chr. Pharyn..........
Tonsils: 1, 2, 3, 4..........Removed totally, partially ....
Vac.: R. L. arm, leg, doubtful, irreg., good.
Heart: rate.......... Regular, irreg., interm., A_2 P_2.

From med. line {
Left nipple =..........cm.
L. bord. card. dul. (5th sp.) =..........cm.
R. bord. card. dul. (4th sp.) =..........cm.
Ap. imp. Seen, felt =..........cm.

Murmurs ....
Lungs..........
....

B. P. standing. S..........mm. D..........mm. recumbent S..........mm. D..........mm.
Abdomen: norm.......... Hernia:..........ing.........., fem.........., ...umb.........., epig..........
Liv.: edge..........felt. *Spleen:*..........felt. *R. Kid.:*..........felt. *L. Kid.:*..........felt.
Penis: norm., circum. *Testes:* R..........L.......... Abnormality: *Varicocele:* R..........L..........
Lymph N.: C.......... Ax..........Epitr..........Ing..........
Knee J.: R..........L..........

Feet: {
History ....
Tender points ....Shoes..........
Use ....

Long arches: R. high, low, flat. L. high, low, flat. Ant. Arches: R. present, absent. L. present, absent.
Blood: Hgb. = ...% (Tallquist)
Urine: Sp. G. = Alb. = Sug. = Sed. =

it was possible to obtain co-operation with the family physician for the benefit of the employee in a number of instances. There was one response from a family physician who took considerable offense at the physical examination and at the report which was sent to him. A good deal of care was taken not to develop a treatment clinic. The cases were seen a number of times, if necessary, but only in order to make a final diagnosis. Cases who needed treatment were of course turned over at once to the family physician, and this action in a number of instances received favorable response.

After a year had elapsed the firm decided that it would be glad to conduct a re-examination, again merely offering the opportunity to those who wanted it. Of the 539 re-examined 106 asked that letters be sent. From the original examinations and the second examinations valuable impressions were gained. Of course there was the inevitable small number of cases of serious unsuspected organic disease. These included a case of tuberculosis of the kidney, which resulted in the removal of a kidney completely destroyed by tuberculosis; a very early case of lymphatic leukemia and a few cases with positive Wassermann reactions. The Wassermann test was performed on the group of 666 men. The total number of positive Wassermanns was only 8. All but one of the cases with positive Wassermanns frankly admitted, after the Wassermann was reported positive to them, that they had had syphilis or syphilitic symptoms some years previous, and the findings of a positive Wassermann was gratefully received as the necessary impetus to renew treatment. The re-examinations at the end of a year were expected to be of a good deal of interest. The examiner was usually another physician; furthermore, after a lapse of a year one would have an opportunity to see if there had been any developments which ought to have been noticed the year previously. It is gratifying to record that the findings of the first examination were confirmed in practically every case and that in the course of a year there were no developments in this considerable group of cases which one could say ought to have been detected earlier.

The experience in this group and in the group at Harvard College has once more confirmed the experience of others, namely that in the examination of the apparently healthy the discovery of the serious unsuspected organic lesions is only occasional. If health examinations were to be evaluated solely on the basis of discovery of serious organic lesions then health examinations would make a poor showing. A striking feature of the value of health examinations as has been pointed out repeatedly is the discovery of defects which are functional and usually remediable. I refer to such defects as improper diet, constipation, the laxative habit, headache, poor posture, inadequate exercise, debility, and lowered efficiency. I think that it may fairly be said that one serious objection that the laity makes against the medical profession is that the medical profession is too prone to state to an individual who is suffering "you are organically sound and there is nothing the matter with you." If health examinations are to be satisfactorily carried out by the medical profession the medical profession will have to say "although you are organically sound there is much the matter with you from a functional point of view."

In 1925 Dr. Elliott P. Joslin, as President of the Harvard Medical School Alumni Association, not being satisfied with securing a dormitory for the benefit of the Medical School students, began the campaign for health examinations for the medical students. The subject had been under discussion for a number of years. It is a curious thing that the Medical School had not set before the students the example that it expected students to carry out in practice. The medical schools in general have been rather slow to adopt this procedure for the benefit and as an example to the medical school students. The Staff of the New England Deaconess Hospital offered to carry out this examination without expense to the Harvard Medical School. The Medical School availed itself of this offer, made the health examination compulsory and took the responsibility of the bothersome arrangements of the schedule. It was my pleasant duty to take charge of these examinations and it is a pleasant privilege indeed to refer even in scant terms to the splendid co-operation of the relatively small staff of the Deaconess Hospital who cheerfully added this not inconsiderable burden to their usual daily work. Perhaps the burden fell heaviest upon Dr. Howard F. Root, who made all the arrangements at the Deaconess Hospital, and who besides doing the lion's share of the examinations was always ready to fill in in any capacity. These health examinations at the Harvard Medical School will be described at some length. In the first place it was emphasized throughout that there were two purposes in view; 1—the obvious benefit to the student, and 2—the demonstration to the student of what a health examination was. From what I have already said it is understood, I hope, that it has been my experience that most physicians are not trained in health examinations, and therefore are unfamiliar and a little innocent of the rather special technical methods involved. It would seem that if each student himself were made a demonstration of the physical examination each year throughout his four years in the Medical School he would be in a position to carry out these health examinations more effectively himself.

Although all of the resources of the New England Deaconess Hospital were available for this examination it seemed that the whole purpose of the demonstration would fail if the examination were made too elaborate or if it included as a routine too many elaborate tests. The criterion was to accomplish a complete physical examination with a small amount of equipment within a reasonable time. In other words the standard was of good general practice. In conformity with good general practice, if there was definite indication for special laboratory procedure or for consultation with a specialist, these were arranged. As a routine, laboratory tests, other than hemoglobin, urine and Wassermann were not performed. It seemed to us that the collection of a vast amount of data would set up

HARVARD MEDICAL SCHOOL

PHYSICAL EXAMINATION—HISTORY BLANK

This History Blank should be filled out fully and carefully *before* you are examined.
The information is solely for the doctor's use and is held confidential.
Bring the blank with you filled out, at the time of your appointment.
If you are in doubt how to answer any questions, leave the answer blank, and speak to the doctor about it when you come for your examination.
Bring a specimen of urine passed the night before the examination in a clean 6 or 8 oz. bottle, labelled with your name.

Name in full.................................Class.................M.................Date..................
Home Address..
Present Address..
(married, single, widowed, divorced)..
Family Physician.................................Address..................................
Do you want the findings of this examination sent to him?..................................
Age.................................Birthplace.................................Years in U.S.A..................
Previous occupation..

FAMILY HISTORY

Father well; died; age.................disease.................; sick; disease.................
Mother well; died; age.................disease.................; sick; disease.................
.........brothers well; age.................died; age.................disease.................
.........brothers well; age.................died; age.................disease.................
.........brothers well; age.................died; age.................disease.................
.........sisters well; age.................died; age.................disease.................

.........sisters well; age.................died; age.................disease.................
.........sisters well; age.................died; age.................disease.................
wife or husband well; died; age.................disease.................
.........children well
.........children died; age.................disease.................
.........children died; age.................disease.................
Cancer, tuberculosis or insanity in family..................................

PREVIOUS HISTORY

Underline and give approximate age at which you had any of the diseases listed:

Measles
Whooping Cough
Mumps
Chicken-pox
Scarlet Fever
Diphtheria
Typhoid Fever
Malaria

Smallpox
Pneumonia
Pleurisy
Rheumatism
Tonsillitis
Influenza
Running ear
Gonorrhea

Syphilis
Chorea
Convulsions
(others)
....
....
....
....

Operations, with age..
....
Eyes:.................Glasses.................for reading.................constantly.................
Date of last examination..
Teeth:.................Visits to Dentist.................Regular.................How often.................
Date of last visit..

a standard which could only be obtained in the hospital or with the very wealthy. When the student received his appointment he also received a history sheet. This history sheet will be illustrated later. He put down the usual information concerning his family and past history, with operations, etc. In addition there were questions concerning the amount of time lost recently, number of colds and number of headaches.

HABITS

Do you live in a lodging house:........ or with your family in a house with........ rooms; or
in an apartment with........ rooms. Number of other members of the household........

Breakfast: time of day:........ Lunch: time of day:........ Dinner: time of day:........
food........ food........ food........

Meals at home........ At restaurants........
Do you eat between meals?........ Specify........
How many cups or glasses do you drink daily of each?
........Tea ....Coffee ....Milk ....Water ....Cocoa ....Chocolate
Bowels: Regular........ Irregular........ Regulated by medicine........
Appetite........ Meals regular........ Average time taken with each........
Do you suffer from indigestion?........ State symptoms........
What is your daily practice in the use of tobacco?
........Cigars ....Cigarettes ....Pipefuls ....oz. Chewing Tobacco
What is your practice in regard to alcohol........
Exercise: Kind........ Regular........ Amount........
Bathing: Times a week........ Kind........
Sleep: Average amount........hours. Usually well........ poorly........ irregularity........
Do you get up regularly at night to pass urine?........ How often each night?........
Weight: Greatest:........ 5 years ago:........ 1 year ago:........
How much time have you lost from illness in the last two years?........
How many headaches do you average a year?........
How many colds do you average a year?........
Home study: Average week day........hours. Average Sunday........hours........
Do you do outside work?........ Specify........
General condition at present (state fully)........

Have you any apprehensions in regard to your health?........
When did you last consult a doctor?........ For what?........
When were you last examined?........

There were also the questions concerning diet, exercise, sleep, bowels and the like. At the end of the history questionnaire was the definite question as to whether there were any problems which he would like to discuss with the examiner. It is found in actual operation that such a history sheet saves about a half hour of the doctor's time. In other words if such a device as the history sheet is not used the doctor must allow approximately a half hour towards securing the information. With the history sheet and with a specimen of urine the student presented himself at the appointed time for his examination. While he was getting his clothes off the doctor looked at the data on the history sheet and could begin to visualize the individual to be examined. The examinations were conducted with all the clothes removed. It is worthy of more than passing remark the very favorable impression that the removal of all of the clothes made. Practically all of the students had been previously examined, but there were numerous comments that on previous examinations no clothes were removed. There seemed to be no difference in this respect between the group of Medical Students, who were all college graduates, and the men of the large industrial organization. The examiners carried out a routine physical examination, a copy of which will be shown later. Half an hour was allowed for the physical examination and the discussion. After a certain amount of facility had been attained in the use of the forms, the examiner found that half an hour was sufficient to carry out the type of examination set and to have time for simple discussion. If any organic disease was dis-

HARVARD MEDICAL SCHOOL
PHYSICAL EXAMINATION

Name in full ...... Class ...... M ...... Date ......
Color ...... Apparent age ...... Peculiarities ......
Eyes: Right ...... Left ...... Corrected to: Right ...... Left ......
Hearing: good, fair, poor. Needs aurist ......
Gen. Devl.: excel., av., poor. *N.:* thin, av., obese. *Skin* ......
Scars ......
Acne: face ...... chest ...... back ......
Posture ......
Distribution of fat and hair ......
Chest: cir. at xiphoid
Exp. ...... in.
Neu. ...... in.
Ins. ...... in.
Shoulders: norm., round. *Scapula:* norm., scaphoid.
Chest: norm., flat, funnel, pigeon, flaring at base.
Girth at umbilicus ...... in.
Vert. Col.: norm. Lordosis: ...... Scoliosis: ...... dors ...... lumb ......
Weight: ...... lbs. *Height:* ...... *Pup.:* R. ...... L. ...... re. to l. and d. ...... Size ...... dance ......
Teeth: good, av., poor, neglected, false. *Thyroid:* norm., sl. enlarged.
Nose: obstruction R. L. nostril ...... Chr. Pharyn. ......
Tonsils: 1, 2, 3, 4 ...... Removed: totally, partially ......
Vac.: R. L. arm, leg, doubtful, irreg., good.
Heart: rate ...... Regular, irreg., interm., A_2 P_2.
From med. line
Left nipple = ... cm.
L. bord. card. cul. (5th sp) = ... cm.
R. bord. card. cul. (4th sp) = ... cm.
Ap. imp. seen, felt = ... cm.
Murmurs ......
Lungs: ......
B. P. recumbent S ...... mm. D ...... mm.

Abdomen: norm. ...... Hernia ...... ing ...... fem ...... umb ...... epig ......
Liv.: edge ...... felt. *Spleen* ...... felt. *R. Kid.:* ...... felt. *L. Kid.:* ...... felt.
Penis: norm., circum. *Testes:* R. ...... L. ...... Abnormality ...... *Varicocele:* R. ...... L. ......
Lymph N.: C. ...... Ax. ...... Epitr. ...... Ing. ...... *Hemorrhoids* ......
Knee J: R. ...... L. ......
Feet:
History ......
Tender points ...... Shoes ......
Use ......
Long arches: R. high, low, flat. L. high, low, flat. Ant. arches: R. pres. abs. L. pres. abs.
Blood: Hgb ...... % Tallquist. Wassermann reaction ......
Urine: Sp. G. ...... Alb. ...... Sug. ...... Sed. ......
Other Physical Findings ......
Summary ......
Advice ......

covered or if any particular problem arose these cases were marked for follow-up interviews. It must be obvious that it is impossible to keep to a schedule if the health examination is going to undertake in the same interview to meet all the varied problems that may suddenly appear. It has been my experience both in examination of groups and in the examinations of individuals in private practice the patient understands perfectly the necessary limitations of time and is perfectly willing to come back for a follow-up interview. The majority of students were told of the findings and were given requisite advice and then told that if there should be any positive findings in the urine or in the Wassermann they would subsequently be sent for. In this group of 495 students the Wassermann in every case was negative, except one, which was doubtful. The Wassermann was repeated three times and came back doubtful each time. This student had a chronic icterus and his doubtful Wassermann was unquestionably due to his icterus. If the student was under competent medical attention for any ailment that sufficed, consequently our figures of consultations may be slightly low. In all there were 65 nose and throat consultations, 13 ear consultations, 36 skin consultations, 36 orthopedic consultations, 13 eye consultations and 30 heart consultations, or a total of 193. There were 3 basal metabolisms performed, all of which were normal. There was one other student who had had his basal metabolism done, which was high. There were 8 electrocardiograms taken and 94 Xrays. Of course some of these were in the same individual. These figures are given to illustrate how many special procedures and special opinions were regarded as necessary under those conditions in which there were no financial considerations. Put in another way three out of every four of these students seemed to require nothing more than the general examination. Less than one in five seemed to need an Xray examination. In some cases this was the Xray of a single tooth, etc.

Total number of students examined	**495**	
OPERATIONS:		
Appendix	68	or 13.7%
Tonsils	219	or 44.2%
Hernia	23	or 4.6%
GLASSES:		
Users	252	
Constantly	120	
Reading	132	
SMOKERS	311	
HEADACHES	284	
Average number per year of those having headaches	6	
COLDS	452	
Average number per year of those having colds	3	
Average loss of time per year	5 days	
CONSULTATIONS:		
Nose and throat	65	
Ear	16	
Skin	36	
Orthopedic	36	
Eye	13	
Heart	30	
Basal metabolism	3	
Electrocardiograph	9	
Xrays—all kinds	94	

Total number of students examined	**495**	
DIAGNOSES:		
Tuberculosis—Total	23	or 4.6%
Tbc. suspects	15	
Old Tbc.	4	
Old Tbc. of spine	2	
Tbc. of cecum	1	
Arrested Tbc.	1	
Heart—Total	21	or 4.2%
Rheumatic heart	3	
Rheumatism with heart	7	
Heart without history of rheumatism	8	
Congenital heart	1	
Duodenal Ulcer	3	
Operation	1	
Goitre	6	
Operation	1	
Albuminuria—Total	4	or 0.8%
Orthostatic albuminuria	2	
Glycosuria	9	or 1.8%

It is believed that such a health examination as was conducted in the case of the Harvard Medical Students can be recommended to the profession at large. To be sure the form is rather more complicated than the form recommended by the Massachusetts Medical Society. But forms are only means to an end and the Massachusetts Medical form is frankly a basic minimum. Such an examination can be carried out in the office in one hour. It is essentially such an examination that I find eminently satisfactory in my office.

Before discussing the advantages, perhaps it would be well to take up possible disadvantages of this examination in particular and health examinations in general. Perhaps the most common objection to health examinations is that such an examination tends to make the patient introspective, that it informs the patient of defects which cannot be cured and concerning which the patient had best be left in blissful ignorance. Like yourselves I have seen examples of disturbance by ill-advised medical comments. But ill-advised medical comments are not confined to health examinations. It is my conviction that a very large part of the difficulty is due to the fact that doctors are mostly accustomed to dealing with the sick and that they interpret symptoms and signs from that viewpoint. During ten years at Harvard University I suffered much from the ill-advised emphasis by physicians upon insignificant systolic murmurs, albuminurias of adolescence, blood pressure variations and other manifestations that were perfectly compatible with health. These so-called abnormalities, particularly the insignificant systolic murmur, were discovered almost invariably not in a health examination but because of some trifling symptom located near the supposed abnormality. Perhaps I suffered most from that still prevalent bugaboo, the Athletic Heart. All this, mind you, was before the term health examination had come into common use. The remedy of the situation obviously is an appreciation of the possible variations in health, and the more health examinations are being performed, the quicker some of these delusions will be dispelled. There are times when I have wished passionately that no blood pressure machine had ever been devised. Such desperate moments are probably common to all of us. Nevertheless the solution, I believe, is not to prohibit all blood pressure apparatus by law, but to demonstrate to the profession and to the laity that variations in blood pressure are very common, that by simple procedure, as by holding the breath alterations of 50-100 m.m. of mercury are common, and that many years of life, health and happiness are possible with a blood pressure which may be elevated over 200, or 250. Gradually I believe the profession will become as conversant with variations of signs in health as it is with similar variations of the cardinal signs of the various diseases.

A second common objection is that most health examinations will not detect symptomless tumors, and that many other conditions would require for detection the thorough examination of a competent specialist in every case. It is even urged that either the person should be put through all possible procedures or left alone. One pauses to query, including a lumbar puncture, cistern puncture, cystoscopic and proctoscopic examination? It is necessary to draw an arbitrary line somewhere. If my own experience is any guide, it is that re-examination and the survey of the year after the first examination, rarely brings to light events or defects which ought to have been detected. And these examinations have been carried out by a considerable number of physicians, some of whom had only surgical hospital training, some of whom were young, some of whom were old, I think all of them were moderately intelligent and ordinarily conscientious. Of course it may in any given case be necessary to have special procedures or a special opinion. The point is that the doctor conducting the health examination isn't necessarily required to be a universal specialist, but he is required to know when special procedures and special opinions are desirable. That is a very different thing. There are few individuals in the State of Massachusetts, too remote or otherwise so situated so that really necessary special procedures or opinions are not fairly readily available.

However, it must be remembered that, although a careful conscientious physical examination is a sina qua non of health examinations, the organic defects discovered in presumably healthy individuals will be few. To my mind of far more importance than the scrutiny of a formidable array of laboratory data is the scrutiny of the human individual himself. He is much more likely to be constipated than to have heart disease. He is more likely to drink insufficient water than to have a brain tumor. He is more likely to need sleep more than he does an Xray. Then all of us have our pet worry. That worry will sometimes be disabused by a laboratory test, but more often by sympathetic discussion.

There are, I believe, certain limitations and possible disadvantages of health examinations. It is necessary to admit frankly that certain incipient diseases may perhaps uniformly escape. The symptomless internal cancer may only be discovered at autopsy. Again there are diseases which even if detected cannot be cured or alleviated. In my opinion it is unfortunate when claims are made for health examinations which cannot be substantiated. To my mind that is like including cancer among the preventable diseases. Every procedure has its legitimate limitations. Experience shows that very few cases of heart disease are overlooked. Indeed the tendency is the other way. Probably more cases are found or suspected than actually are present. On the other hand the situation is different in regard to the lungs. In the course of routine health examinations relatively few tuberculosis suspects are ordinarily discovered. This has always been a source of considerable concern to me. Certainly it is imperative that the health examination should discover a goodly proportion of the potential tuberculous. I think it can be safely said that after a considerable period of uncertainty we are now in a position to define more or less precisely what is meant by a tuberculosis suspect. Again what has happened is that adequate data have been collected concerning normal individuals. Today certain Xray findings which rather recently were viewed with alarm are regarded with cheerful composure. Furthermore the pioneer work of

Name..............................Address..............................Date..............

M. S. W. D. Sex......Age........Race...........Occupation..............................

Tropics...........Vacc..

Family Hist.:.. Can. T. B. Insan.

....

Marital History:..

Menses: Last date.........reg., irreg.dur.....interval....Pain 1,2,3,4 Amt. 1,2,3,4 Leuc. 1,2,3,4

Past History: Measles......Mumps........Ch. Pox........Pertussis......Sc. Fever........

Dipth.......Typhoid......Malaria........Pneum.........Sm. Pox.......Pleurisy.........

Rheuma.....Tonsilitis....Influ...........Otitis..........Gon..........Lues............

Chorea......T. B.........Colds..........Conv...........Fractures.......................

Operation...

Eyes..................................glasses. Ears: deaf......Tinnitus........otorrhea

Teeth: good, poor, false............Dentist..

Tea........Coffee........Alcoh...........Tobacco..........Milk..........Water..........

Diet: coarse......sweet......protied.......Liquid......Regular....eat between meals......

Sleep.......................Exercise......................Baths.........................

Chief complaint;........ ....T.......P.......R......

Present illness ....started................. ....

....Headache..............

....Cough.................

....Blood..................

....Appetite...............

....Bowels.................

....Nocturia...............

....Sweats.................

....Dypsnoea..............

....Pain...................

....Vomit..................

....Malena.................

....Skin...................

....Mental.................

....Wt. $\pm$..............

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....A.A.Cushing,M.D.................

....

PHYS. EXAM.

Gen. App. Devel.: good, av., poor. . . *Nour:* thin, av., obese. *Skin:* ....

. . . *Posture:* A. B. C. *Chest:* nor., flat, dep. *Wt*............*Ht*..................

Eyes:.......................*Ears:*....................*Thyroid:*....................

Glands:.....................*Spine:*....................*Breasts:*....................

Nose: obs...........*Mouth:* m. m...........tongue............tonsils, 1, 2, 3, 4..............

Chest: neut..............insp.............expir.............*Girth:* umbilicus..................

Heart: rate..............................reg., irreg., interm., A_2 P_2.

From med. line { L. nipple..............................cm. Thrill..............

L. bord., card., dull......................cm. Apex..............

R. bord., card., dull......................cm. Pistol shot.........

Murmurs..

Arteries, temporal............................radial....................................

brachial tort...Bl. Pr.......................

Lungs:..

Abdomen: Level, dist., scaphoid masses...........Tender..........Spasm..................

Liver, dull, from 5th rib..................edge felt..........Spleen...................

Kidney........................Costo V. A.....................Masses...................

Hernia..

Extremities: Oedema..................Tremor..................Clubbing...................

Joints...Arches...................

Reflexes, K. J..............Clonus................Babinski....................

Kernig...........Romberg...

Pelvis: Hemorrhoids.....................Pilo N. Sinus...................................

Rectal.........................Vaginal..

Prostate.......................Genitals.................Varicocele...................

Blood: Hgb..................Wassermann..

Urine: Color.........Sp. Gr.........React.........Alb...........Sug...........Bile..........

Acetone.............Diacetic................Sed...

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....A.A.Cushing,M.D.............

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Dr. H. D. Chadwick of Westfield Sanitarium, upon which the so-called 10-year tuberculosis program of the Department of Public Health of Massachusetts is based, has shown that it is not the physical examination of the lungs alone, nor the pulmonary symptoms, nor the Xray findings, but it is the sum total of a good many factors, of which of large importance are such general factors as underweight, fatigue, etc., upon which the diagnosis of tuberculosis suspect is made. In the examination of the Harvard Medical students particular stress was put on the discovery of tuberculosis suspects. It was known that for a period, approximately 10 percent of the graduates broke down with pulmonary tuberculosis. While there is some evidence that that percentage is diminishing, yet it represents a challenge to the health examinations. The examination of 495 students disclosed 15 tuberculosis suspects. These were checked of course by Xray. To discover these suspects 37 Xrays of the chest were taken. This raises at once interesting points. 1—Was a reasonable percentage of tuberculosis suspects actually discovered? 2—Roughly speaking what percentage of Xrays should be positive in order that one should find most of the suspects and at the same time avoid unnecessary expense. It is my opinion that if Xrays are not negative in at least half of the cases, probably not enough Xrays are being taken and probably tuberculosis suspects are being missed. Of course as we all know the interpretation of the Xray is the crux of the problem. However those who are familiar with the interpretation of Dr. Lawrie B. Morrison and Dr. Bogan will understand the feeling of confidence that we have in the Xray findings of the Harvard Medical School students.

Let us frankly grant the legitimate limitations of the health examinations. Let us also grant the occasional ill-advised medical comments. Let us also grant that few spectacular findings of fatal disease in curable stages are made. The large value of the health examination is elsewhere. The large value of the health examination consists in the scrutiny not only of the individual as a whole but of his daily habits. When health examinations were first introduced there was a strong tendency to separate the examination into various portions. One physician took heart, another, lungs, etc., etc. This segmented examination rather lost sight of the individual as an integral unit. It is for this reason that the weight of experience favors the complete examination by one physician, supplemented if necessary by special procedures or special opinions but finally interpreted to the patient by the original physician.

The daily habits of the individual give often illuminating information. I have already said that it is possible to use a questionnaire and save half an hour of time. Personally I prefer to get the history myself. Of decided importance in the history is a description of an average day from getting up to bedtime, including of course the diet. A description of activities over the week end is likewise often illuminating. We also want to know how much time is lost from work in the last several years. Such simple questions often furnish a complete insight into a background on which headache, fatigue and relative inefficiency are built. Before the history is finished, directly or indirectly it must be ascertained if the patient has any special apprehension or problem. Often the clue to the apprehension is found in a family history of tuberculosis, cancer or insanity. I believe that the physical examination should be built directly upon the history. Ordinarily the physical examination takes 15 to 20 minutes after the history of about 30 minutes. It is my custom to take blood for the Wassermann test on every adult male. I find that most of them are decidedly interested in having it done, especially when it is carefully explained that it is a customary routine and not an aspersion against their character. Personally I do not take Wassermann as a routine on women, but I always do if there are even faint indications. The urine is done as a routine. I prefer an evening specimen as more apt to show slight albuminurias and glycosurias. I do not like morning specimens as mild diabetics are overlooked in that way. I usually get a specimen in the office. I prefer to do a sediment, but in the clear urine of young adults I do not believe that is necessary in the absence of albumin. I do a hemoglobin and a stained blood-smear. I am dubious about the value of the routine smear. Personally I do not do eye tests as a routine, in the office. I have occasionally found it of value. I do very rough hearing tests. For the rest of the examination, a tongue depressor, a stethoscope and a blood pressure apparatus are all that are required, besides certain measuring tools. I take the height and weight. I measure the chest and I measure the belly at the navel. The latter measurement is valuable in re-examination to cut down calories and to induce exercise. I also measure the heart borders. Of course with indications I examine the rectum or the female pelvis.

With the physical examination over, the physician has perhaps 10 or 15 minutes of his hour, sometimes less. Consequently only if the case is simple, can the case be dismissed for a year on that visit. One can give simple advice, directions about consulting an oculist or a nose and throat man etc. in that time. Arrangements can be made for an Xray examination. About 25 to 33 percent of the patients will have to be seen again, for the follow-up interview. Sometimes these follow-up interviews are merely to be sure that the patient is following instructions. I believe that the follow-up interview is not sufficiently used. It takes time to "get over" sound health habits. The re-examination is the time that the most effective work can be done on health habits.

I find that it takes practically as long for a reexamination as for an examination. Frequently the reexamination gives the patient an opportunity to ask questions that he was not prepared to ask a year before. The follow-up interviews will not be so many.

I find in reviewing the health examination with the patient, I usually can assure him that he is organically sound, and I mention specifically, heart, lungs, kidneys, blood pressure, etc. A good many patients are nowadays sufficiently sophisticated to ask how much is the blood pressure. I believe that with most patients it is a mistake to give precise figures and I tell them so frankly. I explain how easily variations in blood pressure occur and how some individuals, perhaps 20%, have a labile blood pressure, i. e. under certain conditions, as the excitement of an examination, the blood pressure may be temporarily elevated. I am apt to point out that the diastolic pressure, which has not yet become part of the lay jargon, is perhaps of more importance than the systolic pressure. Usually next in order I take up posture, general physique, and weight. Often posture and the use of the feet can be taken care of during the course of the examination. I still prefer the term of body mechanics and I use as illustrations charts devised by Dr. L. T. Brown for use with the Harvard College students. Suggestions regarding posture and the use of the feet are usually gratefully received. I look at shoes to see if the shoes are sound. Many business men are flabby and they will welcome definite directions as to exercise. Weight is nowadays a universal problem as half the world is trying to get thin and the other half to get fat. If the patient should lose weight, he should return for the usual carefully supervised regimen.

Next in order come the ordinary habits of life, or what is generally known as "taking care of oneself." I think that the staff of the Deaconess Hospital were rather amazed at the rather poor general condition of the Medical Students and the heedless neglect of ordinary rules of health in many instances. Young men who had been athletic, suddenly ceased all exercise, ate irregularly, tried to get on with insufficient sleep, etc. Here and there was a young man who needed to see an oculist, a nose and throat man, or some specialist. With the Medical School students Dr. George L. Tobey, Jr., saw each student with defective hearing, made a permanent record of his hearing capacity by means of the audiograph. An audiogram taken each year will show graphically the progress of his hearing. The deaf have a special handicap and it is extraordinary how rarely the deaf who come for health examinations have had their handicap discussed in relation to their occupation.

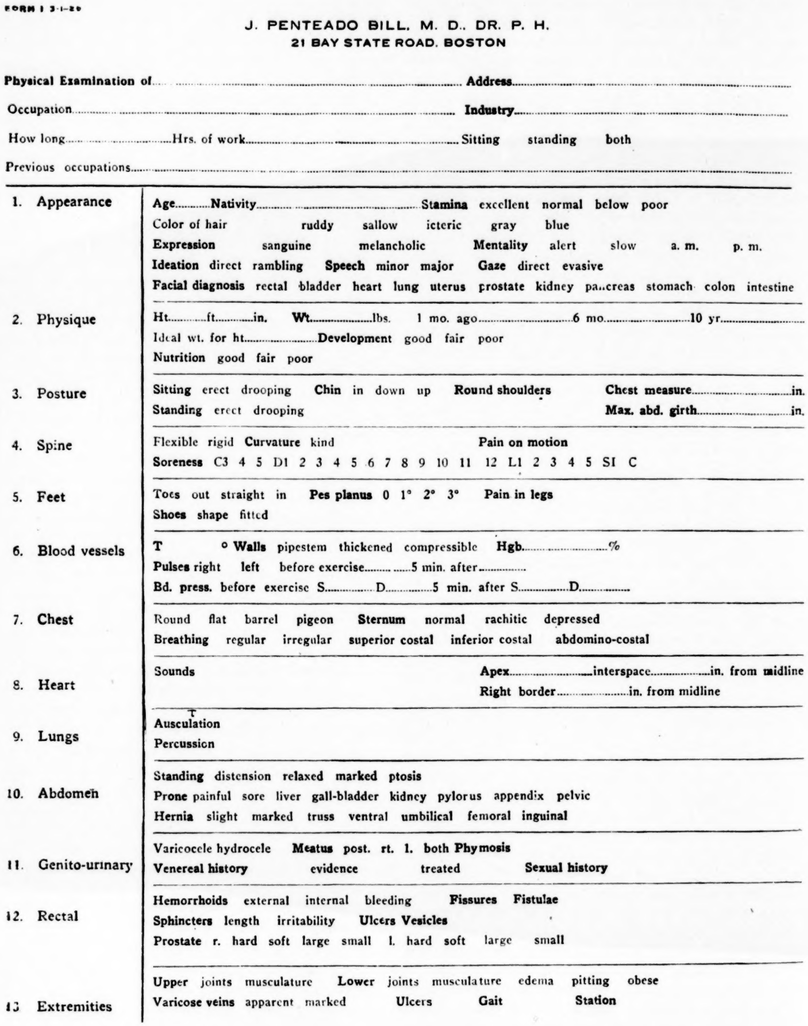
Each individual present his problems. There are few to whom one can say "I find nothing the matter and I have no advice." Usually the findings and the advice, both of which must be recorded, come under several headings. A sample in a private patient might be under findings; Poor posture, Poor feet, Overweight, ? of teeth, Insufficient exercise, Too little sleep, Financial worry and under advice: Posture, Feet, Diet, Exercise, Dentist, Sleep and Advice. Of course the doctor can't give financial advice, but he can tell the patient that worry depends far more on the individual and his health, for which something can be done, than upon the so-called causes for worry. We all know that in our practice the most ardent worriers seem to us and the world at large to have the least to worry about.

It may well be urged that the doctor doing a health examination really practises a bit of dermatology, orthopedics, psychiatry and all of the specialities. The answer is, why not,—if he keeps within the range of his own capacity. Furthermore it is my belief that if the individual has to be referred for a special procedure or for a special opinion or treatment, he should after this disintegrating episode, be again reformed into an integral unit by the examiner who, I repeat, should be the family physician.

It makes, I think, a better impression, if no prescription is given as the result of a health examination. I appreciate fully that the laity regard a prescription as a just and sometimes necessary dividend for the visit to the Doctor's office. However the health examination must be regarded as entirely different from an ordinary office visit, in every way, including the fee. I believe that patients are getting to understand this, perhaps more than most doctors realize. It is more satisfactory to put off to an office visit, any definite treatment, even the beginning of a weight reducing program and to confine the time at one's disposal to the items more properly germane to the health examination.

In advocating a rather arbitrary type of health examination, with an arbitrary preliminary time limit of one hour, I do not in the slightest disparage other types of health examinations. Among others my friend Dr. J. P. Bill has devised a remarkably complete form of history and examination that his patients find most satisfactory. There is ample need for this type of examination although perhaps it is not suited to widespread use.

From a considerable experience with health examinations my conviction grows that the general practitioner should carry out these examinations. I am sure that he is entirely competent. He can and ought to utilize the experience and data of group examinations for his own purpose. There is a specialized technic requiring some special information. This is not difficult to acquire. There are many kinds of health examinations and many forms. A considerable experience justifies the statement that a health examination along the lines indicated meets the general requirements, because it is within the capa-



FORM I 3-1-20

J. PENTEADO BILL, M. D., DR. P. H.
21 BAY STATE ROAD, BOSTON

Physical Examination of .... **Address** ....

Occupation .... **Industry** ....

How long .... Hrs. of work .... Sitting standing both

Previous occupations ....

1. Appearance	**Age** .... **Nativity** .... **Stamina** excellent normal below poor Color of hair ruddy sallow icteric gray blue **Expression** sanguine melancholic **Mentality** alert slow a. m. p. m. **Ideation** direct rambling **Speech** minor major **Gaze** direct evasive **Facial diagnosis** rectal bladder heart lung uterus prostate kidney pancreas stomach colon intestine
2. Physique	Ht......ft......in. **Wt**..........lbs. 1 mo. ago.............6 mo.............10 yr............ Ideal wt. for ht.............**Development** good fair poor **Nutrition** good fair poor
3. Posture	**Sitting** erect drooping **Chin** in down up **Round shoulders** **Chest measure**............in. **Standing** erect drooping **Max. abd. girth**............in.
4. Spine	Flexible rigid **Curvature** kind **Pain on motion** **Soreness** C3 4 5 D1 2 3 4 5 6 7 8 9 10 11 12 L1 2 3 4 5 SI C
5. Feet	Toes out straight in **Pes planus** 0 1° 2° 3° **Pain in legs** **Shoes** shape fitted
6. Blood vessels	**T** ° **Walls** pipestem thickened compressible **Hgb**............% **Pulses** right left before exercise...........5 min. after........... **Bd. press.** before exercise S..........D..........5 min. after S..........D..........
7. Chest	Round flat barrel pigeon **Sternum** normal rachitic depressed **Breathing** regular irregular superior costal inferior costal abdomino-costal
8. Heart	**Sounds** **Apex**..........interspace..........in. from midline **Right border**..........in. from midline
9. Lungs	**Ausculation** **Percussion**
10. Abdomen	**Standing** distension relaxed marked ptosis **Prone** painful sore liver gall-bladder kidney pylorus appendix pelvic **Hernia** slight marked truss ventral umbilical femoral inguinal
11. Genito-urinary	Varicocele hydrocele **Meatus** post. rt. l. both **Phymosis** **Venereal history** evidence treated **Sexual history**
12. Rectal	**Hemorrhoids** external internal bleeding **Fissures** **Fistulae** **Sphincters** length irritability **Ulcers** **Vesicles** **Prostate** r. hard soft large small l. hard soft large small
13 Extremities	**Upper** joints musculature **Lower** joints musculature edema pitting obese **Varicose veins** apparent marked **Ulcers** **Gait** **Station**

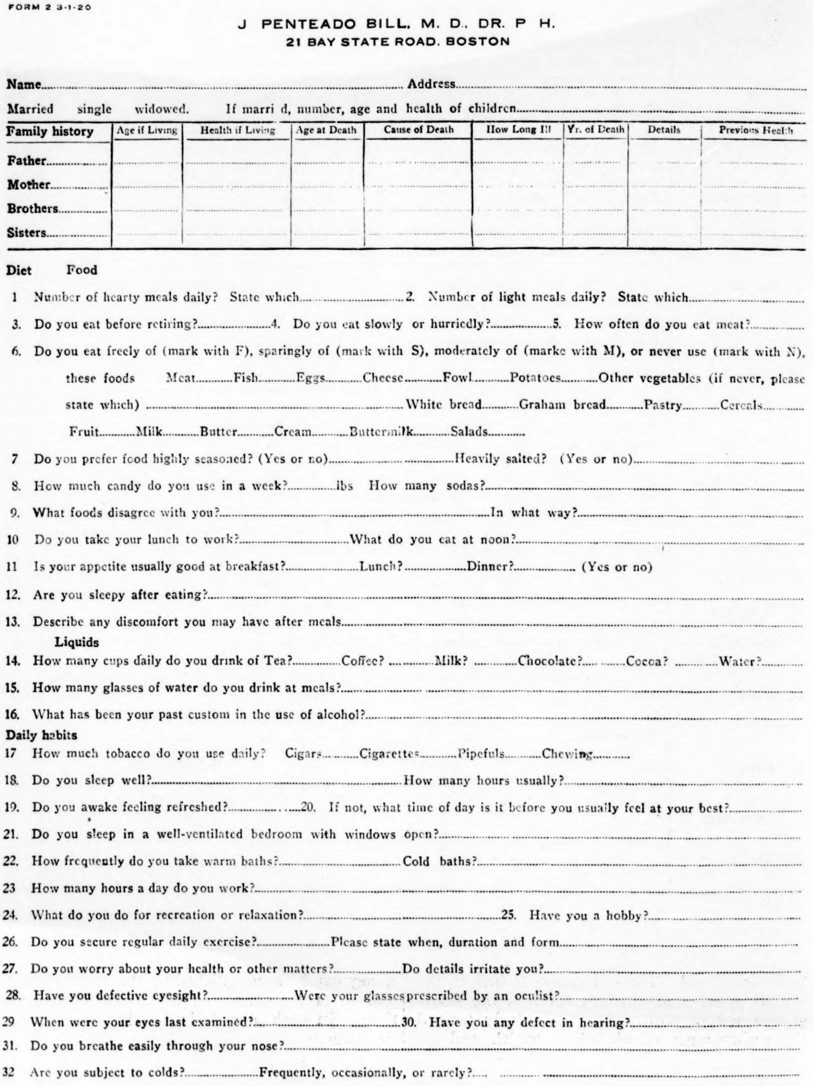
bility of the general practitioner, it is within the financial range of the general class of private patients and there are no large chances of error. There is an obligation on the part of the profession to acquire greater familiarity and facility with health examinations. The introduction of health examinations into Medical School will help in this regard. Sanitary science has made and probably will make in the future great contributions towards the prevention of disease and the maintenance of health. Laboratory science has given and will also give us potent measures

14. **C. N. S.**	**Temperament** normal nervous phlegmatic sanguine melancholic **Reflexes** pupillary R. L. accommodation R. L. **Patellar** Fibrillation **Coordination**
15. **Skin**	Dry clammy eruptions **Scars** accident operation disease **Prophylaxis** Typhoid when **Small Pox** when
16. **Ductless glands**	**Thyroid** enlarged functional exophthalmos **Adrenals** functional pigmentation
17. **Lymphatics**	**Nodes** normal prominent where **Infection** specific
18. **Nose**	**Septum** deviated **Turbinates** enlarged catarrhal **Polypi** **Breathing** R. L. **Adenoids**
19. **Mouth**	**Teeth** good fair poor **false** upper lower carious **Last treated** **Pyorrhea** **Breath** normal foul ammoniacal **Uvula** **Tonsils** enlarged septic inflamed ragged removed when.. **Tongue** coated fissured **Sinuses**
20. **Ears**	**Hearing** R......................./10 L......................./10 Cerumen Drums
21. **Eyes**	**Sclerae** **Irides** Vision R 20/............... L 20/............... **Glasses** needed always worn reading **Color vision** **Astigmatism** spheres prisms **Conjunctivae**
22. **Gynecological**	**Pregnancy Children** living dead miscarriage **Pelvic disorders** past present **Mammary** past present **Menstruation** normal painful profuse irregular prolonged scanty none
23. **Bowels**	Regular irregular constipated **Movements** 1 2 3 **No odor** **acid** **foul**
24. **Addenda**	
25. **Complaint**	
26. **Corrective**	**Diet bowels baths liquids tobacco sleep vocation avocation posture** **exercise worry sex life hygiene of occupation**
27. **Urine**	**Amount** **Sp. gr.** **Color** **Reaction** **Odor** **Alb.** **Sugar** **Microscopical**
28. **Feces**	**Odor** **Color** **Character** **Microscopical** **Occult blood**
29. **Other tests**	
30. **Therapy**	

Time..**a. m.**..**p. m.**

Date examined..**192**.....

to the same end. There is reason to believe that similar great contributions towards the saving of life and perhaps more particularly towards the maintenance of abundant health and efficiency can be accomplished by the individual attention of the physician to the individual patient. In such a contribution health examinations ought to play an important part.



FORM 2 3-1-20

J PENTEADO BILL, M. D., DR. P H.
21 BAY STATE ROAD, BOSTON

Name.. **Address**..

Married single widowed. If marri d, number, age and health of children......................................

Family history	Age if Living	Health if Living	Age at Death	Cause of Death	How Long Ill	Yr. of Death	Details	Previous Health
Father..............								
Mother..............								
Brothers..............								
Sisters..............								

Diet Food

1 Number of hearty meals daily? State which..............................2. Number of light meals daily? State which..............................

3. Do you eat before retiring?......................4. Do you eat slowly or hurriedly?......................5. How often do you eat meat?..............

6. Do you eat freely of (mark with F), sparingly of (mark with S), moderately of (marke with M), or never use (mark with N), these foods Meat..........Fish..........Eggs..........Cheese..........Fowl..........Potatoes..........Other vegetables (if never, please state which) ....White bread..........Graham bread..........Pastry..........Cereals.......... Fruit..........Milk..........Butter..........Cream..........Buttermilk..........Salads..........

7 Do you prefer food highly seasoned? (Yes or no)..............................Heavily salted? (Yes or no)..............................

8. How much candy do you use in a week?..............lbs How many sodas?..............................

9. What foods disagree with you?..In what way?..............................

10 Do you take your lunch to work?..............................What do you eat at noon?..............................

11 Is your appetite usually good at breakfast?......................Lunch?......................Dinner?...................... (Yes or no)

12. Are you sleepy after eating?..............................

13. Describe any discomfort you may have after meals..............................

Liquids

14. How many cups daily do you drink of Tea?..............Coffee?..............Milk?..............Chocolate?..............Cocoa?..............Water?..............

15. How many glasses of water do you drink at meals?..............................

16. What has been your past custom in the use of alcohol?..............................

Daily habits

17 How much tobacco do you use daily? Cigars..........Cigarettes..........Pipefuls..........Chewing..........

18. Do you sleep well?..............................How many hours usually?..............................

19. Do you awake feeling refreshed?....................20. If not, what time of day is it before you usually feel at your best?..............................

21. Do you sleep in a well-ventilated bedroom with windows open?..............................

22. How frequently do you take warm baths?..............................Cold baths?..............................

23 How many hours a day do you work?..............................

24. What do you do for recreation or relaxation?..............................25. Have you a hobby?..............................

26. Do you secure regular daily exercise?......................Please state when, duration and form..............................

27. Do you worry about your health or other matters?......................Do details irritate you?..............................

28. Have you defective eyesight?......................Were your glasses prescribed by an oculist?..............................

29 When were your eyes last examined?..............................30. Have you any defect in hearing?..............................

31. Do you breathe easily through your nose?..............................

32 Are you subject to colds?......................Frequently, occasionally, or rarely?..............................

33. Are they usually of the nose and throat, chest or both?........

34. Is your house heated by stove, hot air, or radiator?........Your place of business?........

35. What is your custom about underwear in winter?........

36. Are you bothered with headaches?........(Severe, mild, frequent, rare.)........Indicate where........

37. At what time of day do they usually appear?........

38. Do you take patent medicines for any condition?........If so for what?........What do you take?........

39. Are you bothered with constipation?........ 40. How many free movements weekly?........

41. Are the stools usually gray, light, dark or black?........

42. How often during the day do you pass water?........At night?........If at night, when did the habit commence?........

43. Is your vigor greatest in winter or summer?........

44. Are you specially sensitive to heat in summer or cold in winter?........

45. Have you ever had a nervous breakdown?........If so, describe and state duration........

46. To what do you attribute the cause?........

47. Have you ever had any severe illness or injuries?........ 48. Have they affected your present health?........

49.

Name of disease	No. of attacks	Date	Duration	Severity	Results

50. Do you now suffer (N), or have you ever suffered (P) from the following troubles?

Dizziness		Shortness of breath		Chills	
Rheumatism of joints		Blood spitting		Vomiting blood	
Other forms of rheumatism		Severe abdominal pain		Discharge from ear	
Chronic skin disease		Pain about heart		Distress after eating	
Sleeplessness		Backache		Headache	

51. What bothers you most about your present condition?........

52. Is your health in any other way affected?........

For those previously examined.

53. Have you endeavored (by medical treatment or advice, correction of faulty living habits, etc.) to better your health since your last examination? (Please give full details)........

54. Are you aware of any improvement in your condition? (Answer as fully as possible)........

Date........ Signed........

Clin. No...

Date..

BOSTON DISPENSARY HEALTH CLINIC

25 BENNET STREET

This History Blank should be filled out fully and carefully before you are examined by the doctors in the Health Clinic.

The information is solely for the doctor's use and is held confidential.

Bring the blank with you, filled out, at the time of your appointment at the Clinic.

If you are in doubt how to answer any questions, leave the answer blank, and speak to the doctor or the clinic secretary about it when you come for your examination.

Name..

Home Address..

Business Address..

OCCUPATION (last five years)

Inclusive Dates	Occupation	Nature of Work	Hours

Age.................................. S. M. W. D. Birthplace.. Years in U. S. A..............................

FAMILY HISTORY

(check if positive in parents, brothers or sisters, and give brief details)

Check		Brief Details
	Heart or Kidney Disease	
	Consumption or Pleurisy	
	Cancer	
	Hardening of Arteries	
	Shock or Paralysis	
	Insanity or Nervous Diseases	

PREVIOUS HISTORY

(check diseases with dates; name others if not included in list)

Check	Disease	Date	Check	Disease	Date	Check	Disease	Date
	Measles			Scarlet Fever			Rheumatism	
	Tonsilitis			Malaria			Typhoid Fever	
	Persistent Cough			Blood Spitting			Pleurisy	
	Pneumonia			Syphilis			Gonorrhoea	
	Running Ear			(Other)				

How much time have you lost because of sickness during the last two years..

F 170-500 12 23

HABITS

How many cups or glasses do you drink daily of

TEA	COFFEE	MILK	WATER	COCOA	CHOCOLATE
............Cups daily	............Cups daily	........Glasses daily	........Glasses daily	............Cups daily	............Cups daily

What is your practise in the use of tobacco?

CIGARS	CIGARETTES	PIPEFULS	CHEWING TOBACCO
............................Daily	............................Daily	............................Daily	......................Oz. daily

Appetite.............................. Meals regular?.................. Average time taken with each:..

Do you suffer from Indigestion?......................Nature:...
(Number of times daily)

Nature of food: Meat.............................. Potatoes.............................. Other vegetables........................... Eggs.............................

Exercise: Kind.. Regular.. Amount...

Bowels: Regular.. Irregular.. Regulated by medicine...

Recreation. Amount and character...

Bathing: Times a week.. Kind...

Sleep well?.. No. of hours...

Do you get up regularly at night to pass urine?............... If so, how often each night?...

Have you any apprehension in regard to your health?...

Weight: best.. 5 years ago.. 1 year ago.......................................

General condition at present (state fully):..

....

....

....

....

....

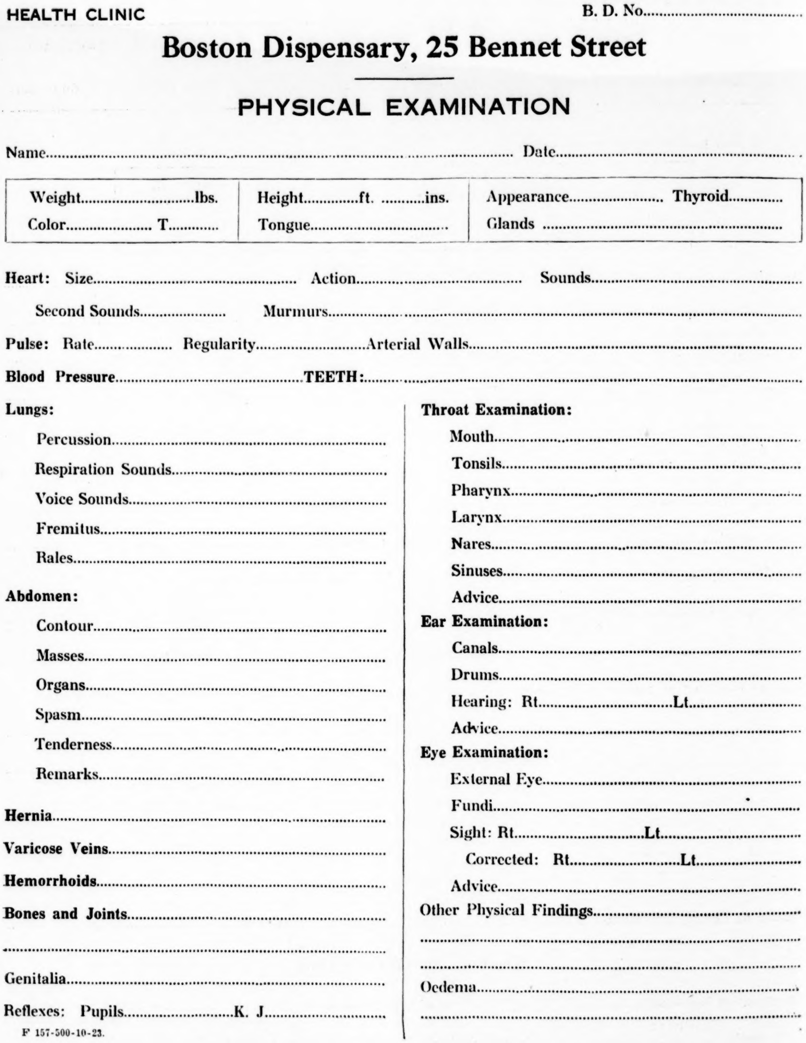
Name of family physician.. **Address**..

Questions for Women Only

Menstruation began at..yrs. of age. Stopped at..yrs. of age.

Is it regular?.. Is pain sufficient to force you to go to bed?..

No. of children.. No. of miscarriages...



HEALTH CLINIC B. D. No..

Boston Dispensary, 25 Bennet Street

PHYSICAL EXAMINATION

Name.. Date..

Weight..............................lbs.	Height..............ft. ....ins.	Appearance........................ Thyroid..............
Color...................... T............	Tongue..................................	Glands ....

Heart: Size.. Action.. Sounds..

Second Sounds...................... Murmurs..

Pulse: Rate.................... Regularity...........................Arterial Walls..

Blood Pressure..**TEETH:**...

Lungs:

Percussion..

Respiration Sounds...

Voice Sounds..

Fremitus..

Rales..

Abdomen:

Contour..

Masses...

Organs...

Spasm..

Tenderness..

Remarks..

Hernia..

Varicose Veins...

Hemorrhoids...

Bones and Joints...

....

Genitalia...

Reflexes: Pupils............................K. J..............................

F 157-500-10-23.

Throat Examination:

Mouth...

Tonsils..

Pharynx..

Larynx..

Nares..

Sinuses...

Advice...

Ear Examination:

Canals...

Drums...

Hearing: Rt.................................Lt................................

Advice...

Eye Examination:

External Eye...

Fundi..

Sight: Rt...............................Lt.....................................

Corrected: Rt...........................Lt.................................

Advice...

Other Physical Findings...

....

....

Oedema...

....

Laboratory Findings. Urine..

....

Blood Smears..

....

....

Wasserman..

Other Tests..

....

....

Tabulation of Findings. General Medical..

....

....

Nose and Throat..

Ear..

Eye..

Genito-Urinary..

Dental..

Other..

Summary of Findings..

....

....

(Were Findings given to Family Physician: Yes....................No....................)

Advice to Patient..

....

....

....

Case Records of the Massachusetts General Hospital

ANTE-MORTEM AND POST-MORTEM RECORDS AS USED IN WEEKLY CLINICO-PATHOLOGICAL EXERCISES

EDITED BY R. C. CABOT, M.D.
F. M. PAINTER, A.B., ASSISTANT EDITOR

CASE 13141

PAIN IN THE RIGHT FLANK AND CHEST

MEDICAL DEPARTMENT

A colored widow eighty-four years old came to the Emergency Ward January 29 complaining of pain in the right upper flank.

She was comparatively well until a year before admission. Then she began to have dysphagia and gas with occasional vomiting, never of blood, increasing until in the past two weeks even liquids seemed to stick in her epigastrium. In the past week aching of the right flank and lower thorax had developed, without cough and not aggravated by breathing. She had had moderate dyspnea on exertion. She had failed markedly and had lost weight during the past few months. Her bowels had been constipated.

Clinical examination showed an emaciated old woman, markedly debilated but without definite complaints except pain in the right flank. The skin was very dry and atrophic, like parchment. The sclerae were subicteric. Teeth, a few old roots. Pyorrhea. Coarse tremor of tongue. Poor chest expansion. Lungs poorly aerated, hyperresonant. Location of apex impulse of the heart not recorded. Percussion measurements: left border 8.5 centimeters, midclavicular line 7 centimeters, right border 2 centimeters, supracardiac dullness 4.5. Action regular. Sounds of fair quality. Loud systolic murmur over the lower left precordium. Artery walls thickened and tortuous. Blood pressure 60/40. Irregular liver edge palpable 4 centimeters below the right costal margin in the mammary line. Coarse tremor of hands. Marked Heberden's nodes. Pupils equal, regular, small, no reactions. Fundi not satisfactorily seen.

Urine not recorded. Blood: 12,600 leucocytes, 88 per cent. polynuclears, hemoglobin 65 per cent., reds 4,176,000, smear normal. Wassermann negative. Non-protein nitrogen 45 milligrams. Clotting time 5 to 12 minutes. Icterus index 10. Stool negative.

During the eighteen hours the patient was in the hospital her chief complaint continued to be aching in the right upper flank and right chest, sometimes involving the right shoulder, with at times some high epigastric burning also. The day after admission she died.

DISCUSSION

BY RICHARD C. CABOT, M.D.

DIFFERENTIAL DIAGNOSIS

The outstanding symptom, so far as I see, is dysphagia, with some dyspnea and loss of weight. The physical examination shows emaciation and arteriosclerosis, with rather surprising little anemia, with an irregular liver, and possibly some jaundice—the icteric index is on the line between increased and not increased. With such negative lungs in the absence of any fever I do not see how we can make any diagnosis of an infectious disease. The natural thing to think of is cancer of the cardiac end of the stomach or of the esophagus. The liver seems to be involved, that is, if it is genuinely irregular. An irregular liver is very seldom cirrhotic, almost always cancerous. The irregularities of the syphilitic liver are so coarse that they are not usually described in this way in the physical examination.

What is the cause of this pain in the right flank and lower right chest I do not know. Nothing in the physical examination throws any light on it. It might well be connected with the liver, possibly caused by the stretching of the liver capsule by a nodule of metastatic neoplasm.

This, I think, is the conclusion that anybody would have to come to on the face of the record as we have it. But in a person so old, and of this race, living in the hospital so short a time, and with so unsatisfactory a history, one should be prepared for being wholly off the track, finding, for example, miliary tuberculosis or some condition for which there is no basis in the history or physical examination.

I suppose we did not get X-rays. She was presumably too sick. And I think this is the sort of case where they would not have been justified in trying to get more satisfactory information, being obtained, as it would have been, at the cost of the patient's strength.

A PHYSICIAN: If she had arteriosclerosis could she live eighty-four years? How long did she have it?

DR. CABOT: Yes. The longer you live the more arteriosclerosis you have. The older people are in general the more sure we are that they have it. I do not think we have any good evidence that arteriosclerosis shortens life in every case. It goes along with old age, and if it does not happen to come in the wrong place, like the coronary artery, I do not think we always have proof of its shortening life.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Carcinoma of the liver?
Senility.
Arteriosclerotic heart disease?
Coronary thrombosis?

DR. RICHARD C. CABOT'S DIAGNOSIS

Carcinoma of the liver?
Arteriosclerosis.

ANATOMIC DIAGNOSIS

1. *Primary fatal lesions*

Arteriosclerosis, marked.
Dissecting aneurysm of the first portion of the arch of the aorta with rupture into the pericardium.

2. *Secondary or terminal lesions*

Cholelithiasis.
Chronic cholecystitis.

Dr. Mallory: Dr. Cabot has said several times this winter that in cases of sudden death in the hospital we very often do not find the cause post mortem. And here is a case where we have a cause for sudden death, but the death was not sudden. This patient had an extremely severe arteriosclerosis which resulted in a dissecting aneurysm of the aorta. At one point the entire internal sheath of the aorta had been torn off. From the appearance you might easily suppose this tear here was an artefact that we had introduced, but this huge sheet was actually flapping in the current. The break in the intima is of considerable duration, as shown by a thrombus between the internal and external walls. But in the terminal moments perforation had taken place in the external wall also, and there was a large hemorrhage into the pericardium. This was the immediate event which led to her death.

Otherwise the findings were not very remarkable. She had a moderately congested liver, but the most noticeable thing about it was the distension of the bile-ducts, and that proved to be due to a large stone of half the diameter of the common bile duct. The gall-bladder was also filled with smaller stones. She had a number of calcified foci of healed tuberculosis in the lungs. The other organs were negative.

A Physician: Was the heart enlarged?

Dr. Mallory: No, the heart I should say was very little enlarged.

CASE 13142

Surgical Department

AN UNUSUAL ACUTE ABDOMINAL CONDITION

A mechanic sixty-four years old of Irish parentage entered December 14 complaining of abdominal pain and vomiting.

The symptoms came on eleven days before admission while he was at work. The attack kept him in bed. The pain had been less severe for the past few days. The vomiting had persisted. He had been unable to keep anything on his stomach. The vomitus contained bile; nothing that looked like blood. Once four days before admission it contained numerous black particles. His physician had given him several injections of morphia; none recently. During the illness his bowels had been constipated. He had had three enemas. The first gave very good results. His last bowel movement was a day and a half before admission following an enema. The stools had never been black or bloody.

No family history was obtained.

He had usually had good health and had always worked hard. His habits were good. Eighteen years before admission he had "ptomain poisoning" and pain in the lower abdomen. Seven years before admission he was away from work for several months because of a "breakdown." He had some digestive symptoms. Since that time he had had discomfort after meals at infrequent intervals, relieved by induced vomiting, soda or a warm drink.

Clinical examination showed an old man lying in bed, indifferent to all that went on about him, in little or no pain. His skin showed small telangiectatic blebs on the lower chest and abdomen. There were many decayed and foul teeth. The lungs were clear except for fine crackling râles at both bases. The heart was not enlarged. There was a very slight systolic murmur at the base and over the aortic area. The radials showed slight thickening. The blood pressure was 145/100. The abdomen showed no tenderness or spasm. A questionable mass was felt in the epigastrium slightly to the left of the median line. The pupils were equal, regular, sluggish to light and distance. The knee-jerks were absent.

Before operation the amount of urine was 33 to 80 ounces, specific gravity 1.018, sediment 10 to 20 leucocytes per high power field. Blood: 15,000 leucocytes, hemoglobin 90 per cent., reds 4,100,000. Wassermann negative. December 14 non-protein nitrogen 113 milligrams, chlorides 392 milligrams, carbon dioxide tension 61.5 volumes per cent.; December 15 non-protein nitrogen 86 milligrams, chlorides 552. Stools: guaiac more or less positive at one examination, negative at another; no fats.

Before operation the temperature was 98.2° to 103° with gradual upward trend, marked December 19 and 20; pulse 80 to 127, respirations 18 to 32.

The patient was given glucose intravenously and saline by hypodermoclysis. His condition improved. December 16 to 20 he vomited small amounts daily.

December 21 operation was performed. He did not react well after it. The general condition was very poor the following day. The vomiting continued. He was given gastric lavage and subpectorals. He grew steadily weaker. December 23 the temperature rose to 108°, the pulse to 135. That day he died.

DISCUSSION

BY EDWARD L. YOUNG, JR., M.D.

The question of visualizing the patient I think is rather difficult from this story alone. Apparently it was a pretty severe onset, because it immediately laid him up in bed. He had to have morphia. He vomited, and has continued to vomit, not only up to the time of admission but even later. When he came in he was dehydrated, his chlorides were low, his non-protein nitrogen high. The leucocytosis I think means very little to us under those conditions. That, with a temperature that varied of course suggested a septic process somewhere.

The abdominal examination helps us very little. The suggestion that we get in his past history of indigestion is not enough to point strongly to organic disease of the stomach. It does however suggest the possibility of biliary tract disease. On that basis an acute cholecystitis might have been present to start with. We should hardly expect it to go for nearly three weeks, giving him persistent vomiting. He has had a great deal of constipation. His bowels have not moved except with enema apparently, and that is enough to suggest the beginning shut-down of carcinoma. We always think of carcinoma in a man of this age with beginning abdominal symptoms. The sudden onset suggested perforation, but a perforation, except for a very definitely walled-off perforation, would not go this length of time without death from peritonitis.

The other thing that we can possibly hitch on to biliary tract disease coming on suddenly is pancreatitis. Pancreatitis often causes symptoms suggesting intestinal obstruction for the time being. The temperature would fit with that, and this questionable mass in the left side. If he had pancreatitis he ought to be tender on that side, and the mass ought not to be very definite.

In almost any man of sixty-four in poor general condition an appendicitis must always be mentioned, because it can be present with the most unusual symptoms. I do not think it is appendicitis. I should assume that the diagnosis was not definite here.

They kept him, got his fluids built up, which resulted in the restoration of the chlorides to normal and the bringing down of the non-protein nitrogen. "Guaiac more or less positive at one examination" I think means very little.

Then he was operated on. I do not see that on the basis of this story we can make a definite diagnosis. The only thing that we have here is the suggestion of a mass in the left upper quadrant—apparently it was not very definite—and a suggestion of trouble in the chest. I assume, from the fact that that is not mentioned more, that clinically they assumed it was not a bronchopneumonia. On the theory of chances, which is about as good a basis as we have in this story, I suppose malignant disease would come pretty close to the top, biliary tract disease including pancreatitis a very good second, and I should think everything else an extremely poor third. I assume that it was an operation on the basis of a continuation of vomiting, the suggestion of trouble in the upper half of the abdomen given by examination.

DR. YOUNG'S PRE-OPERATIVE DIAGNOSIS

1. Malignant disease of the intestine with subacute perforation?
2. Subacute pancreatitis?

PRE-OPERATIVE DIAGNOSIS

1. Subacute pancreatitis.
2. Subacute perforation of a gastric ulcer.

OPERATION

Local novocain. Median epigastric incision exposing tumor which presented between the stomach and the transverse colon, extending across the median line upward under the stomach. The gall-bladder was slightly adherent but negative for stones. Fat necrosis was scattered through and over the transverse mesocolon, the omentum and the pelvic peritoneum. The duodenum was exposed. In its third part it was pushed forward by the growth. By blunt dissection above this a large cavity was entered with the finger. This extended across the median line. After walling off, a considerable amount, say a pint, of brownish fluid with colon bacillic odor was evacuated. One tube was placed in this sinus. It was uncertain whether this should be classed as a pseudocyst of the pancreas with subsequent infection or as a pancreatic abscess. However, it represented the result of a pancreatitis. There were some sloughs of tissue found in the cavity, but these were not recognizable.

FURTHER DISCUSSION

He died of a combination of sepsis probably spreading to a beginning peritonitis and the fact that he was in extremely poor condition from his three weeks of trouble.

CLINICAL DIAGNOSIS (FROM HOSPITAL RECORD)

Acute pancreatitis.
Abscess of pancreas.
Drainage of abscess.

DR. EDWARD L. YOUNG'S POSTOPERATIVE DIAGNOSIS

Acute pancreatitis.
Abscess of pancreas.
General peritonitis.

ANATOMICAL DIAGNOSIS

1. *Primary fatal lesion.*

Abscess of pancreas.

2. *Secondary or terminal lesions.*

General peritonitis.
Fat necrosis.
Anthracosis of the lungs, lymph nodes and liver, marked.

3. *Historical landmarks.*

Prostatic hypertrophy.

Dr. Mallory: The operative findings seem to give most of the facts of the case. On opening the peritoneal cavity a small amount of cloudy fluid was found in the pelvis. The omentum was tightly bound with fibrinous adhesions to the neighboring viscera. There were abundant fat necroses in the omentum and throughout the mesenteric fat. The entire peritoneal surface of the lesser peritoneal cavity was completely necrotic. There was an opening into the lesser peritoneal cavity through which a drain had been passed, and in the base of the cavity the head of the pancreas could be made out at one end and the tail at the other. There were approximately four or five centimeters of pancreatic tissue completely missing, the whole such a necrotic mass that it was difficult to identify much in it. I think without much question it was an abscess of the pancreas. There was nothing to suggest definitely a cyst, although it was difficult to say for sure.

The condition in the lungs was apparently only one of extreme anthracosis. There was no evidence of infection. This was an unusual degree of anthracosis, so severe that a great deal of the pigment had passed through the bronchial glands and there was a slight degree of anthracosis of the liver just from carbon deposit there.

The gall-bladder was not free of stones as stated in the operation report. It contained one very large stone about four centimeters in diameter and was clamped down tightly around that. No bile was present.

In the pancreas the lesser duct was made out and seemed patent throughout the usual length. It extended up into the remaining portion of the head of the pancreas. The main pancreatic duct ended abruptly in the abscess cavity, and the probe passed directly into the cavity through the opening into the duodenum.

The other organs were essentially negative.

A Physician: Did you find an ulcer in the duodenum?

Dr. Mallory: No, there was no ulcer.

Dr. Young: I do not suppose there was the slightest way of telling whether that infection might have come from the biliary tract?

Dr. Mallory: Not with certainty. There was no recent infection. There was unquestionably a chronic infection with this big stone and the definitely thickened walls of the gall-bladder, but it did not suggest any recent acute cholecystitis.

THE PUBLIC HEALTH SERVICE'S COMPILATION OF CERTAIN COMMUNICABLE DISEASES

The 93 cities reporting cases cited in the following table are situated in all parts of the country and have an estimated aggregate population of more than 30,860,000. The estimated population of the 93 cities reporting deaths is more than 30,190,000. The estimated expectancy is based on the experience of the last nine years, excluding epidemics.

Weeks ended February 26, 1927, and February 27, 1926.

Cases reported	1926	1927	Est. exp.
Diphtheria			
41 States	1,477	1,743	....
99 Cities	783	1,059	961
Measles			
38 States	20,728	14,192	....
99 Cities	12,058	5,003	....
Poliomyelitis			
41 States	25	13	....
Scarlet fever			
40 States	4,699	6,086	....
99 Cities	1,663	2,517	1,318
Smallpox			
40 States	975	876	....
99 Cities	238	146	141
Typhoid fever			
41 States	188	209	....
99 Cities	29	47	40
Deaths reported			
Influenza and Pneumonia			
93 Cities	1,742	1,078	....

No death from smallpox was reported by any of the 93 cities during the week.

A NEW ANAESTHETIC

The *New York Times* reports that a new discovery given the name of 107 will supplant ether and chloroform. This is a bromine preparation which is given by enema. Anaesthesia is prompt.

Dr. Ernst Unruh, director of the Rudolph Virchow Hospital, Berlin, reported three hundred successful tests. Although only about five hundred cases have been treated by 107, the doctors are reported as optimistic with respect to the effects of this agent which they claim is devoid of danger to the patient. The claims for 107 were presented at a meeting of the Berlin Medical Society, March 24, 1926. Excitement and vomiting do not follow the administration of the anaesthetic. If extended study and experience will demonstrate all that is claimed for 107, another boon to society is available.

THE BOSTON
Medical and Surgical Journal

Established in 1828

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VIS MEDICATRIX NATURAE

WHEN the morning mail is largely composed of "blotters and pills," which so often seems to be the case in these modern times, and bills are introduced into the legislature to provide for special qualifications to treat the sick, one turns for relief to our old Boston friend, Jacob Bigelow, and reads his Massachusetts Medical Society discourse, of 1835, "On Self-Limited Diseases." There is no better antidote for the young physician! In it one finds an excellent quotation from Sir Gilbert Blane's "Medical Logic" as follows: "The benefits derivable to mankind at large, from artificial remedies, is so limited, that if a spontaneous principle of restoration had not existed, the human species would long ago have been extinct." This important contribution of Bigelow's served at the time to call attention to the world of the value of rational therapeusis and led in part to the doctrine of so-called "therapeutic nihilism." The pendulum, however, has now swung a little back from its extreme position of a decade or two ago.

Two recent books have served to call again to our attention the importance of the concept expressed by Bigelow. Dr. Max Neuburger[1] has outlined, in a small volume, the history of the evolution of the belief in the healing power of nature. He feels that the gradual recognition of this principle has been one of the most powerful ideas in the history of medical thought. It is the great antidote of the ignorant polypharmacy, so rife in the 16th and 17th centuries, which still lurks among the best of us at the present time, and its perennial "rediscovery" by half educated minds is largely responsible for the ubiquitous cults and faith-healing. Recognition of the extent and limitations of the healing power of nature by the laity would do much to stamp out the quack and the charlatan.

The study of the history of pharmacy also serves to show us the extraordinarily close relationship between quackery and drugs. LaWall[2], in his recent volume, clearly demonstrates the swing of the pendulum from Digby's "sympathetic powders" and the "doctrine of signatures" to the extreme protest against the use of any but a few drugs.

Medicine, however, has always succeeded in separating the wheat from the chaff, although the process may be a slow and irregular one. Like the advancement of science itself, medicine proceeds slowly upwards in a spiral motion, every now and then turning back and facing the same problems in the same manner of a century or more before, but always, fortunately, at a higher level and with a clearer view of the whole problem at hand.

REFERENCES

1 Neuburger, Max: Die Lehre von der Heildraft der Natur im Wandel der Zeiten. Stuttgart: Enke, 1926. 8+212 pages.
2 LaWall, Charles H.: Four Thousand Years of Pharmacy: An Outline History of Pharmacy and the Allied Sciences. J. B. Lippincott Company, Philadelphia and London, 1927. 15+665 pages.

PLAGUE AND INFLUENZA

IT is reported that plague has invaded Africa, and that natives are dying by thousands. Whether it is the true bubonic plague is not stated, although, of course, it is known that this form of plague originated either in Asia or Africa, and certainly in times gone by destroyed multitudes on both those continents.

A question which has been, and is being discussed freely at the present time, is as to whether the Black death which devastated Europe in the medieval era, was bubonic plague. From the account given by Daniel Defoe, of the great plague of London, it seems that that deadly epidemic was bubonic plague. The conditions were favorable for its spread, as the London of that period was incredibly dirty and rats abounded. Also the description of the disease handed down by writers of the time, its extreme virulence, its contagious character and its symptoms generally appear to agree with the classical picture of bubonic plague, and also, it may be noted that after London had been cleansed thoroughly by the fire, the dirty wooden houses replaced by structures of brick or stone and the rats driven out, no big epidemics occurred.

Positive and negative evidence go to show that the European "Black death" was the plague. However, while the point is not absolutely proved, the fact remains that plague retreated from Europe, and now only takes its toll of life, in such places as China and India and in Africa where filthy conditions prevail and the rat, the carrier of its host, thrives abundantly.

Instead of the plague, Western Europe is from time to time devastated by influenza, although again this is no new disease in Europe, nor in other parts of the globe, nor, of course, is it confined to that continent, but in pandemic form sweeps through the whole world, leaving a wake of death and disability among human beings and animals. According to authorities, it is safe to say that influenza in that fatal winter of 1918-1919, killed twice as many people as were killed in the Great War, although the War's death roll is computed at 8,543,515 of all the combatant nations.

The cause of bubonic plague is known, and it has been shown that by taking necessary precautions, the institution of efficient sanitary measures, the disease can be driven out. In the case of influenza, the cause is not known, neither are any preventive measures certainly effective, nor is treatment wholly to be depended upon. It is a mystery disease in many respects. Not the least of its mysterious and sinister aspects is that it suddenly takes on an extreme virulence. It seems to have the effect of exciting certain micro-organisms present in the body, to a high degree of toxicity. The resisting powers of the system are of no small account in the struggle with the invader, indeed the natural immunity of a healthy body is the strongest defence, against disease. Therefore, the aim to prevent disease, influenza included, is to maintain the defences of the body at their highest standard. Perhaps, the fortification of the host may be found to be, in the long run, the best means of defeating the enemy. In any event, it is almost obvious that efforts must always be directed to the removal of the conditions, in seed and soil, which make for disease. The soundest strategy against a disease of unknown strength, as influenza, is not a frontal attack, but flank movements, an attempt at preventive treatment. In the meantime, investigations into the causation of influenza, its mode of spreading, and into the reasons why it becomes highly virulent, should be redoubled. It is hardly to the credit of the medical profession that so little is known of one of the oldest and deadliest epidemic diseases extant.

"THE CARE OF THE PATIENT"

THE attention of readers of the JOURNAL is called to the article entitled "The Care of the Patient," written by Francis Peabody of Boston, and appearing in the *Journal of the American Medical Association* of March 19th. This article, which was one of a series of talks before students of the Harvard Medical School, is so sane and so full of what one may call the philosophy of medicine, that it cannot be allowed to pass without comment. Every physician, we, fear, will feel a sense of guilt as he reads what Peabody has to say about "the patients who have nothing the matter with them." All patients have something the matter, or they would not be spending time and money in the pursuit of medical aid. This "something" may be mental or it may be physical, but to the patient it is very real. With great subtlety Peabody points out that those who practice so-called "scientific medicine" are only half scientific if, having failed to detect through laboratory measures any organic disease, they are content with their negative results, and tell the patient he has nothing the matter; "the essence of the scientific method of thought," he says, "is that it proceeds in an orderly manner towards the establishment of a truth." By this one sentence the writer brushes aside the fog that hangs over the controversy now going on between those who advocate "scientific medicine" and those who cry for a return to the "art of medicine," and shows that the object of both is the same. Those physicians who follow their profession because they love it will be grateful to Peabody for the clear statement of the ideals of medical practice contained in his closing sentences. "The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient."

SURVEY OF UTAH STATE HOSPITAL

THE mental State Hospital at Provo, Utah, has recently been carefully surveyed by Dr. George L. Wallace, Superintendent of the Wrentham State School, Wrentham, Mass. The survey was made at the request of the legislature of Utah and Dr. Wallace was chosen on account of his well-known ability and special training in the care of mental patients. He found conditions in Utah extremely bad in many respects. In the twentieth century there have been so many changes in state hospitals throughout the eastern states that it is difficult to realize that in the western part of the country mental patients are still considered as criminals and are put into the jails before being committed to the state hospitals. Apparently it has only been recently realized in Utah that people with mental disease should be considered as sick persons and not as criminals.

Dr. Wallace, in his report to the state legislature, strongly advises a change in the state law and suggests that the new law be modeled on the Massachusetts commitment law. In addition to the inadequate commitment laws, Dr. Wallace found a number of bad conditions in regard to the care of patients. He carefully inspected not only the State Hospital, but the State Industrial School, the State Penitentiary, and other public buildings. He also found that the mental State Hospital was badly overcrowded and that there was an inadequate number of physicians to care for the patients.

The findings of Dr. Wallace's report were later incorporated into a special message by the Governor of Utah to the legislature. He recommended practically all the changes suggested by Dr. Wallace, and it is hoped that the legislators will see fit to put these changes into effect at once.

DR. EDWARD R. BALDWIN OF SARANAC LAKE TO ADDRESS TRUDEAU SOCIETY OF BOSTON

It is with great pleasure that the Trudeau Society of Boston announces that Dr. Edward R. Baldwin of Saranac Lake will address the Society on Tuesday evening, April 12th, at 8.15 at the Boston Medical Library. His subject will be "Tuberculosis Infection, With Especial Consideration of Its Quantity, Virulence and Frequency." The meeting will be open to all, and it is hoped that there will be as large an attendance as possible to give Dr. Baldwin a hearty welcome to Boston.

THIS WEEK'S ISSUE

CONTAINS articles by the following authors:

SCUDDER, CHARLES L., B.A.; Ph. B.; M.D. Harvard Medical School 1889. F.A.C.S. Consulting Surgeon Massachusetts General Hospital, Member American Surgical Association. Chairman Fracture Committee American College of Surgeons. Address: 144 Commonwealth Avenue, Boston. Associated with him are:

HARMER, TORR W., B.A.; M.D. F.A.C.S. 416 Marlboro Street and

THORNDIKE, AUGUSTUS, JR., A.B., M.D. Address: 66 Commonwealth Avenue, Boston.

They present an account of the Fracture Exhibit with Illustrations as submitted at the Annual Meeting of the Massachusetts Medical Meeting in Springfield 1926. Page 555.

LEE, ROGER I., A.B.; M.D. Harvard Medical School 1905. Formerly Professor of Hygiene Harvard Medical School. Address: 270 Commonwealth Avenue, Boston. His subject is "Health Examinations." Page 559.

MISCELLANY

USES OF TYPHOID VACCINE IN ARMY

THE advantages of protective vaccination against typhoid fever that have accrued to the United States Army since the adoption of its general use in 1912 are described in a statement just received at the United States Public Health Service from the State and Provincial Health Authorities of North America. The Public Health Service, it was stated, is coöperating with the organization of Health Authorities in carrying on a program to reduce the incidence of typhoid fever in the United States.

Prior to 1910, when the use of anti-typhoid vaccine was first begun in the Army, from 20 to 100 soldiers in every 10,000 suffered attacks of typhoid every year. By 1912, when protective vaccination had come into general use throughout the Army, the typhoid rate had been reduced to three in every 10,000, whereas in 1915 only eight of every 100,000 soldiers had typhoid.

This is the measure of the progress which the U. S. Army has made against one of its former most terrible scourges. Its medical advisers have availed themselves of and put into effect the best of modern practice relating to environmental sanitation and personal hygiene, and the organization of the Army is such that it has been possible to take advantage of the very great degree of protection afforded by the use of anti-typhoid vaccine as a preventive measure.

Read this epic of medical progress as related by Surgeon General Ireland of the U. S. Army.

The World War demonstrated, on the most vast scale possible, the very great value of prophylactic typhoid vaccine as a preventive measure. During the Spanish-American War about 20,000 soldiers suffered attacks of typhoid and about 2,000 died of it, whereas during the World War there were only about 2,000 cases with approximately 200 deaths. These gross figures, striking though they be, fall far short of representing the actual results obtained in the prevention of typhoid. The number of men mobilized for the Spanish-American War was only about 25,000, while during the World War approximately 4,000,000 men were called to active service. Considered, therefore, in the light of the actual strength of the American armies engaged in the two wars, it can be stated that for every one case of typhoid occurring during the World War 150 occurred during the Spanish-American War.

Our armies fared much better in this respect than did the armies of our Allies. In the French armies, for example, 45,000 cases of typhoid and paratyphoid occurred during the first six months of hostilities.

Not until about the end of the second year of the war was it possible for the French to very completely apply this prophylactic measure.

The value of its use is evidenced by the fact that during the first two years of the war, when vaccine was administered only to limited numbers of men, approximately 100,000 French soldiers had typhoid and paratyphoid fevers, whereas during the last two years, when it was possible to apply this measure generally, only about 2,000 cases occurred. The armies of all of our Allies had a somewhat similar experience, except that the British succeeded in initiating this prophylactic measure through every part of their forces within a few months of the outbreak of the war, with the result that this group of diseases was immediately brought under control.

Today cases of typhoid fever are looked upon as medical curiosities in Army hospitals. During 1925, with an average strength of 136,000 men, only four cases of typhoid occurred in the Army. One of these had recently been enlisted and was not protected by vaccination. The diagnosis was confirmed by recovery of the typhoid organism from the blood. The remaining three had been vaccinated previously. The diagnosis in these cases was based on clinical symptoms and could not be confirmed by laboratory examinations, though such examinations were made. All patients recovered.—*United States Daily.*

THE HEALTH PLAYWRITING CONTEST

Announcement of the judges of the 1926 Health Playwriting Contest was made by the Massachusetts Tuberculosis League recently. The men who will award the three state prizes for plays submitted by the high schools of the Commonwealth in the National Health Playwriting Contest this year will be E. E. Clive, Director of the Copley Theatre, Boston; Carl Schrader, Director of Physical Education, State Department of Education and Dr. John B. Hawes, 2nd, President of the Boston Tuberculosis Association.

Mr. Clive, as in previous years, will not only act as a judge but has given the use of the Copley Theatre for the presentation of the three prize winning Massachusetts plays which will be produced there on the afternoon of Friday, April 29.

Carl Schraeder is widely known as an expert in physical education procedure and for a number of years has been interested in the field of the drama.

Dr. John B. Hawes, 2nd is the author of a number of books and articles on public health and tuberculosis. Under his direction Prendergast Preventorium in Boston is being enlarged from its present size so as to accommodate 100 children this summer.

The State Tuberculosis League also announces two further competitions. Teachers throughout the Commonwealth are invited to enroll in a competition on the subject of health education plans, the prizes for which are scholarships in Massachusetts post-graduate schools this summer.

The second contest is for pupils, classes and schools in photographs of health activities.

Both contests close June 1. Further information may be had at the League office, 1149 Little Building, Boston, Massachusetts.

LEGISLATIVE NOTE

THE CHIROPRACTIC BILL

The Senate recorded its approval of the bill to register chiropractors by a vote of twenty to fourteen.

The Senators voting in favor of the Chiropractic bill are: Annis of Lynn, Bessette of New Bedford, Bigney of Boston, Cashman of Boston, Chamberlain of Springfield, Cotton of Lexington, Cox of Boston, Crockett of Milford, Daggett of Somerville, Gallup of North Adams, Hennessey of Dorchester, Adams reported in the daily press does not appear in the published list of Senators, Haley of Rowley, Hartshorn of Gardner, Holden of Worcester, Johnson of Worcester, Kidder of Cambridge, Martin of Holyoke, Mulvey of Boston, Nicholson of Wareham, and Simoneau of Marlborough.

Those who voted against the bill are Bacon of Boston, Bilodeau of Boston, Cregg of Methuen, Davis of Haverhill, Farrington of Salem, Fish of Brookline, Judd of Southampton, Kincaide of Quincy, Moran of Mansfield, Pond of Greenfield, Shuebruck of Cohassett, Thayer of Lancaster, Webber of East Bridgewater, and Wragg of Needham.

Paired against the bill are Bliss of Malden and Warren of Arlington. Paired for the bill are Perham of Chelmsford and McLane of Fall River.

A change of three votes from the endorsers of the bill to the minority would have made a tie.

Some of the explanations of senators voting for the bill seem to be unreasonable. For example: one senator with a long experience in the legislature is said to feel that the doctors opposing the bill did not appear to have a constructive substitute. If the argument that a single standard of fitness to deal with the human body is not reasonable, we do not know how to appeal to that man's intelligence.

The bill came up for the third reading April 4th, but an amendment was offered which led to postponement with the expectation that further consideration would be given April 5th. The amendment provides for the exemptions found—the law regulating the practice of medicine Section 77, Chapter 112, and further that the provisions of the bill shall not be held to discriminate against any particular school or system of medicine. This amendment is designed to meet the objection that the bill if enacted would prohibit the manual treatment of spinal difficulties by any person other than a chiropractor.

RECENT DEATHS

JORDAN—Dr. Frank Herbert Jordan of New Bedford died in that city March 21, 1927, at the age of 58. He was born in Milton, N. H., September 13, 1868, was graduated from the Medical Department of Bowdoin College in 1899 and settled in Fryeburg, Me. In 1904 he moved to South Portland, where he was city physician in 1908. He was a member of the American Legion and of several fraternal organizations.

SABINE—Dr. George Krans Sabine of Brookline died at his home in that town March 21, 1927, at the age of 79, from paralysis and sequelae. He had been acutely ill for about two weeks.

OBITUARY

GEORGE KRANS SABINE

1847-1927

Dr. Sabine was emphatically a man of his time, one of the few who still linger, and yet his qualities would have fitted him to any time into which he had been born. Born and raised on a New England farm at Windsor, Vermont, he graduated at the University of Norwich in 1868. He carried through life a love of nature which led him to observe closely and to delight in the changing seasons, birds, flowers and plants as work took him in and about Brookline. No less keen and close was his observation of his patients, for whom his care was all embracing. In those lesser things, which in the aggregate count for so much in lessening the pain and weariness of illness, he was a master. Before entering the Harvard Medical School he had the advantage of pupilage, I think, certainly of association with Dr. Phelps, a shrewd, busy country practitioner. Of Dr. Phelps I have heard him often speak and tell many anecdotes.

At the Medical School he was one of the leaders in his class, and then served a year as Surgical House Pupil at the Massachusetts General Hospital. Internes were styled "house pupils" in those days, and were not allowed to take their degree of M. D., although they had fulfilled all its requirements, until the completion of the hospital service. Apparently, it was feared they might assume an undesired responsibility under the title of doctor. The year of his hospital service covered the great fire of '72, and the horse epidemic—epizootic it was called—which was probably responsible for the magnitude of the fire through the delay which it caused in providing first aid. In the winter of '73 an epidemic of small pox and of cerebro-spinal meningitis followed. Then came two busy years in Europe with special interest in pathology. Soon after his return he settled in Brookline where he passed the rest of his life. His qualities soon got him into active, and before long into the leading practice of the town. His knowledge of and deep devotion to his profession, his skill and high character, his humanity and keen sense of humor commanded trust and effection. He never slighted a trust,—and is not a physician eminently a trustee?

His busy life left him little leisure for writing, and only those who came into intimate relations with him, either as patient or colleague, got the benefit of his large, varied and ripe experience. Few men of his stamp are left. It does not seem likely that the future will breed them, at least in or near large cities, so many are the fields of knowledge, so rapidly do these extend and multiply, so intensive is their cultivation.

In the last few progressively disabling years of his life he exhibited a fortitude which he had unconsciously helped so many to attain. The death of a dearly loved, promising and attractive son from pneumonia while in the service during the late war was a severe blow to him, and led him to give his University at Norwich a generous athletic field, the Sabine Field.

To him, and to those friends who made it possible, the gift of a room in the Harvard Medical Students' Dormitory to bear his name must have been and must continue to be a gratifying thought.

He was never guilty of an unworthy act. He leaves behind him a sweet and tender memory, a precious legacy to widow, children and grandchildren.

F. C. S.

GEORGE K. SABINE THE PHYSICIAN

Dr. George K. Sabine, who died at his home in Brookline on March 21, was such a remarkable practitioner that it seems almost the duty of one who was closely associated with him for many years and who had unusual opportunities to see him at work to put on record at least a few notes about him.

He was born on a farm in Windsor, Vermont, and as a boy took an active part in the farm work. I recall his telling of how he drove a flock of sheep across the river to a pasture on Croydon Mountain in Cornish; also of being sent to look out for a carload of cattle coming to his father from Canada which had been sidetracked in the little town of Roxbury, Vermont. Here, unaided, he had to unload the cattle, feed and water them and put them on the car again. It is evident that he worked hard and had unusual responsibilities for a boy.

He was, however, no ordinary farm boy. A boy hoeing corn in a Vermont field who sixty years later could remember just what birds were singing in the woods on the edge of the field was no ordinary boy. He kept his eyes open to all that was going on around him. He knew not only all about farm animals but also about the wild creatures, the birds, the trees and the flowers. He kept up this interest in nature all through his life and as he grew older he more frequently spoke of observations which he had made while a boy.

I mention this interest in nature because I believe it had an important bearing on the development of those qualities which distinguished him as a physician. A keen instinctive knowledge of nature and her methods was the foundation on which his medical education and experience built the great practitioner that he became.

His medical education was begun at McGill and was continued at the Harvard Medical School, where he graduated in 1873. He served as intern at the Marine Hospital in Chelsea and on the surgical service at the Massachusetts General Hospital. After this he went abroad, studying in Vienna and also in Strassburg, where he worked under von Recklinghausen, probably the leading pathologist of that time. When he returned to America there were few in this country who had had such an education as he. The Harvard Medical School might well have sought him for a position on their teaching staff, but it did not and he never applied for any teaching or hospital position. He had no desire for anything but a general practise and this he started in 1875, in Brookline.

At first he had spare time on his hands. He served for a few years as Agent of the Brookline Board of Health and medical examiner for Norfolk County. Within a few years he was head over heels in work. For the two decades, 1885 to 1905, his practise was enormous. He worked under great pressure fourteen to sixteen hours a day without a break for months at a time, and there would often be times when this working day was extended through much of the night.

A large practise, however, is not unusual and it by no means always indicates unusual medical skill. To appreciate Sabine one needs to follow him into the sick room.

It was his custom during the very critical stages of acute illnesses, like pneumonia and typhoid, to have a young physician stay with his patients during the night and sometimes through the day. Serving in that capacity during the late nineties, the writer had his first oportunities to see Sabine at work. And in the care of acute illness he appeared at his best. It was usually after eleven when he came in for his last call, letting himself in quietly with a latch key. He was very apt to carry on his key ring the latch keys of half a dozen houses, the homes of his very sick patients. After seeing the patient, we would, perhaps, come down to a dimly lighted library where on a comfortable sofa he would, in a low voice, talk over the case. Then, apparently oblivious of the hour, he would talk on about other interesting cases out of his rich experience. It was good clinical teaching.

Sabine had no exalted ideas of the value of drugs. He used few and in small doses. His medicine never disturbed his patients, but usually gave a little push in the right direction.

He realized that nature cures the patient, and that the most important way to aid nature in her work was to provide good nursing. And it was in the perfection of the nursing service that he secured for his patients that he excelled anyone in the profession that I have ever seen.

His first care was to secure a good nurse, and he took infinite pains to do this. He always had a long list of nurses that he would like to employ again but it was never long enough. At the registry in the old Medical Library there was no physician in Greater Boston who called for so many nurses as Sabine.

Even with a good nurse (or perhaps several) on the case he would carefully supervise the nursing of the patient and direct every detail. In critical cases he always strove to conserve every bit of the patient's strength and energy, and by making them more comfortable to secure sleep and rest. These he felt were the deciding factors in those few cases where life hangs in the balance and the outcome is determined by treatment.

He was exacting in his demands on his nurses but those who could come up to his standards usually preferred to work for him, because they knew he appreciated efficient and faithful nursing.

Sabine often devised a special technique for carrying out certain forms of treatment with the least possible disturbance of the patient. His former nurses still tell how Doctor Sabine had them do things. He was at his best in those cases which presented special nursing problems. It was wonderful to see his skill in removing the clothing from a severely injured person where every slight motion caused excruciating pain.

The point of it was that the life energies of an unusually keen and resourceful mind were devoted to those small (?) details of general practise, in regard to which most physicians give little thought.

He evidently appreciated the importance of nursing early in his medical career. He told me that while an intern at the Marine Hospital he used to work with the ward tenders doing their work with bedpans, baths, etc., just for the experience. He felt that a weak point in the education of a physician was his lack of any first hand knowledge of the various procedures which the nurse carries out. The doctor orders these procedures without personal knowledge of the amount of disturbance or fatigue to the patient which they entail.

It was extraordinary how Sabine with his long hours of work was able to keep up with the new things in medicine. During the active years of his practise great advances were being made in the scientific side of medicine, especially in the development of laboratory aids for diagnosis. He had an almost uncanny way of seizing at once upon any new thing which was destined to prove to be of permanent value, while he promptly and very forcefully rejected at once many of the new fads to which his colleagues would give a trial.

Thus he instantly recognized the value of cultures for the diagnosis of diphtheria. Inasmuch as a mild sore throat even without membrane might occasionally be due to the Klebs-Loeffler bacillus, he at once made it an invariable rule to make a culture of every sore throat.

This use of cultures in every case was characteristic of the man in all his medical work. He did everything that might possibly be of even remote value to his patients, no matter how tired and hurried he was and no matter how much extra work it entailed. Many men who are busy and hurried become sloppy in their work. This was the last thing that could be said of Sabine. He erred—and intentionally—in doing things that were probably unnecessary.

He was extremely careful in his asepsis and in the precautions he took to avoid carrying infection from patient to patient. Long before there were foot or elbow devices for turning on water in the operating rooms of up to date hospitals, he made it a practise never to touch a faucet after washing his hands and rinsing them in running water. He would use a clean towel or would produce a piece of sterile gauze for that purpose. I never knew a physician to take such care of his stethoscope. He would always clean the bowl carefully after use and put it in a clean white washable bag.

His pathological training and his scientific spirit led him to try to secure an autopsy on as many of his private cases as possible. Several of the undertakers—and they are the only ones who would know—have said that there was no one practising in Greater Boston who had so many autopsies performed on private cases. I know that he often paid the pathologist out of his own pocket and furthermore he made a gift of money to the Pathological Department of the Harvard Medical School, which was to be used to compensate pathologists making autopsies in private homes.

When this country entered the World War in 1917, Sabine was in poor health and quite feeble. Forty years of hard practise were telling on him. Many of his old patients hesitated to call him because he seemed so feeble. And yet his accomplishments during the next few years were truly remarkable and showed the big calibre of the man. He at once began to interest himself in the welfare of the Brookline men in service. His keen mind visualized their real needs, which he did all in his power to satisfy. After the war he continued his interest in the men and it was through his efforts almost exclusively that a club room and headquarters for the local Legion post was secured and furnished. Among all the citizens of the town engaged in this sort of work, his was the outstanding figure. The men appreciated his efforts and spoke of him as "The Legion's 'Daddy.' "

Former patients of Doctor Sabine contributed to a fund to name a room for him in the new dormitory of the Harvard Medical School. The students occupying that room through the years to come will see his name on the tablet, but unfortunately to them it will be only a name. It would be an inspiration to those young men to know of the life work of the man that room commemorates, for he certainly stood for the highest ideals of the profession they have chosen.

F. P. D.

CORRESPONDENCE

Max Baff, M.D.
Physician and Surgeon
Worcester, Massachusetts

Thos. J. O'Brien, M.D., Sec'y,
Committee on State and National Legislation,
Massachusetts Medical Society,
Boston, Mass.

My dear Doctor:

Several days ago I sent you a carbon copy of a letter which was mailed to Representative E. J. Kelly of Ward 3, Worcester, requesting that he use his influence in the House to defeat the Chiropractor Bill now pending. The enclosed letter is the favorable answer which he has sent me, and I forward it to you for your inspection.

You will also find enclosed herewith a letter to the Editor of the Boston Medical and Surgical Journal for publication in that periodical. Such a contribution to the Journal will help the battle against special Boards. Please deliver the article to the Journal Editor's room.

Sincerely yours,
Max Baff, M.D.

141 East Central Street.
March 23, 1927.

COMMENTS ON THE RESPONSIBILITIES OF DOCTORS

Editor, Boston Medical and Surgical Journal:

I presume that an article of this sort not referring to diagnosis or treatment will remain unread by most of the Fellows of the State medical society. At a meeting of the Worcester District Medical Society held in the Memorial Hospital on March 9, 1927, one of the speakers urged that every member of the society (State) lend his influence to his Representative and Senator to vote against the bill now pending in the Legislature. This bill provides for the registration of chiropractors. It seems as if the medical profession is composed of men who think of science and art first and last, but devote no time for developing business methods.

Where would we be today were it not for such men as Dr. Samuel B. Woodward, former President of the State society, who has labored hard for the benefit of every member of the profession and for the welfare of the public! Are the rest of us cripples? Are we afraid to open up our mouths? How many new hospitals would be in existence today were it not for the tireless work of a few men who are not afraid to see their names in print!

A medical student earnestly believes that the earth is very ordinary, and that his father must succeed in business in order that his medical education shall be completed. Receiving checks from his "daddy" becomes a habit, and the student considers it a fair reciprocation if he endorses those paper valuables. But, dear doctor, as soon as Mr. Medical Student obtains his M.D. degree, here is what occurs: Mr. Student suddenly grows fat in his head, which causes it to swell enormously. Hats no longer fit. Clothes become obsolete, and as a result old man "daddy" places a mortgage on his house and a lump on his larynx! Dignity now reigns supreme. It does not need a stimulant to keep it conspicuous. It is all sunshine now. Rainy days never occur, but old man "daddy" sees many of them. A shingle is posted to advertise A. Fathead, M.D. Will this doctor talk to everybody? Will a doctor take his own medicine?

For many years I have contributed to medical journals and the lay press. I have criticized the public service corporations, and some of our public servants, but have found that my practice has not decreased, and have never thought that a doctor of medicine must use a mouth gag, provided that he is sane.

My advice to the average doctor who has two good legs and desires to see fair competition in the practice of medicine is this: Do not fall back in your chair and say that business is "rotten." Perhaps it is your fault.

Do not talk medicine all the time. Take some of it yourself.

Do not admire a large modern hospital. Help to build one.

Do not let the State medical society officers do all of the work to protect you and me. In matters that affect your well-being, just take a few hours away from your prescription pad and pills, and dart to the home of your Representative or write him a letter, and tell him just what is causing that itch under your chin.

If you do industrial accident insurance work, and if you believe in a high standard of medical education, then don't simply think so, because legislators cannot hear your think. Better use your loud speaker; let your larynx radiate and be heard.

Max Baff, M.D.
(Fellow Mass. Med. Soc'y since 1903.)

RESOLUTIONS ADOPTED BY THE NORFOLK DISTRICT MEDICAL SOCIETY ENDORSING THE SINGLE STANDARD WITH RESPECT TO THE LICENSE OF PRACTITIONERS OF MEDICINE

March 29, 1927.

The following resolutions indicating the attitude of the Norfolk District Medical Society toward the Chiropractic Bill were unanimously adopted at a record attendance meeting held on the above date:

"*Be it resolved,* That the Norfolk District Medical Society, consisting of 600 active members, favors a single standard for the practice of medicine in this State as is obtained through the examination and registration of all applicants by a single Board of Registration in Medicine according to the existing law and custom.

"That this Society is opposed to the bill now under consideration in the Massachusetts Legislature, designed to establish a separate board for the examination and registration of Chiropractors for reasons previously set forth by representatives of the Massachusetts Medical Society in attendance upon legislative hearings in connection with that bill.

"That the individual members of this Society in so far as is practicable write the Senators and Representatives of their respective districts urging defeat of this bill. That until the bill shall have been defeated or repealed if made a law, the individual members of this Society shall through their daily contact with their patients advise them for their future guidance as voters in this Commonwealth of the facts concerning Chiropractic and its supporters in their endeavor to legalize special privileges.

"*And be it further resolved,* That the Secretary of this Society be directed to forward copies of this resolution to every Senator and Representative within the Norfolk District, and to every District Society in this State for consideration and action."

Facts concerning the experiences of other States in the matter of division of authority through examination and registration by special boards are a matter of record and will be gladly furnished upon application. We request your active coöperation in the defeat of this bill.

Respectfully yours,
Frank S. Cruickshank, M.D., *Secretary,*
23 Bay State Road, Boston.
C. W. McDonald, M.D., *President.*

CONNECTICUT DEPARTMENT OF HEALTH

Morbidity Report for the Week Ending
March 26, 1927

Diphtheria	20
Last week	27
Diphtheria bacilli carriers	4
Scarlet fever	136
Last week	151
Measles	115
Last week	211
Whooping cough	47
Last week	53
Typhoid fever	1
Last week	0
Bronchopneumonia	51

Chickenpox	131
German measles	11
Influenza	21
Mumps	45
Paratyphoid fever	1
Pneumonia, lobar	66
Septic sore throat	3
Tuberculosis, pulmonary	32
Tuberculosis, other forms	1
Gonorrhea	13
Syphilis	19

NEWS ITEMS

BOOTLEG CREAM—This term has been applied to uninspected cream smuggled into New York State. This business had been conducted on a large scale until the New York State Health Commission started an investigation.

THE GULLIBLE FAT PERSON—Two charlatans have been indicted by the Federal grand jury on the charge of using the mails to defraud fat persons. The treatment consisted of solutions of epsom salts disguised by coloring and flavoring matter.

THE CANCER ENDOWMENT—It is reported that one-half of the one million dollar fund now being raised by the American Society for the Control of Cancer has been given. Dr. R. Fulton Cutting has

offered to give a quarter of a million on condition that the remaining three-quarters will have been secured by next October. It is claimed that more than a million lives have been lost in this country by cancer during the past ten years. Contributions may be sent to Dr. George A. Soper, 25 West Forty-third Street, New York City.

NOTICES

A CORRECTION

The letter under the title of "Boston Tuberculosis Problem," Volume 196, Number 13, Page 543, was written by Dr. John B. Hawes, 2nd, and not John B. Hammond.

An error of this sort is inexcusable, and we apologize to Dr. Hawes.

Dr. Sherman T. Hopkins has been appointed Commissioner of Health for the City of Lynn, and will enter upon the duties of the office as soon as practicable after April first.

ELECTION OF DR. JOHN BARTOL AS PRESIDENT OF THE BOSTON MEDICAL LIBRARY

Dr. George H. Monks has resigned as President of the Boston Medical Library, a position he has occupied since 1919.

Dr. John W. Bartol has been elected by the Executive Committee to fill the place left vacant.

UNITED STATES PUBLIC HEALTH SERVICE

Changes of Duties of Two Commissioned Officers of the United States Public Health Service

Senior Surgeon J. O. Cobb—Directed to proceed from Boston, Mass., to New York, N. Y., and return, to report to board for examination—March 16, 1927.

Surgeon Lawrence Kolb—Directed to proceed from Washington, D. C., to New York, N. Y., and Boston, Mass., and return, on or about March 28, in connection with field investigations of mental hygiene being conducted by the Public Health Service—March 22, 1927.

REPORTS AND NOTICES OF MEETINGS

MASSACHUSETTS ASSOCIATION OF BOARDS OF HEALTH

Regular meeting and luncheon, Park square, Boston, Hotel Statler, 12:30, Thursday, April 28th.

Program: Recent studies and progress in the treatment and control of Whooping Cough as being made by the Whooping Cough Commission of Boston.

Speakers: "Present Day Treatment of Whooping Cough," by Dr. Lawrence W. Smith. "The Bacteriology of Whooping Cough," by Dr. George M. Lawson. Dr. George H. Bigelow, Commissioner of Public Health of Massachusetts, will address those present on the matter of proposed regulations by cities and towns for tourist and health camps, in consequence of pending legislation.

Luncheon will be provided at $2.00 per person.

Stephen L. Maloney, *Secretary.*

Please try to attend and bring a friend.

NORFOLK SOUTH DISTRICT MEDICAL SOCIETY

A meeting for Medical Improvement will be held on Thursday, April 7, 1927, at 12 o'clock noon at the Norfolk County Hospital, South Braintree. Speaker: Dr. Howard M. Clute. Subject: "Differentiation of Diseases of the Thyroid Gland."

N. R. Pillsbury, M.D., *Secretary,*
South Braintree, Mass.

THE MASSACHUSETTS GENERAL HOSPITAL MEDICAL MEETING

The next Massachusetts General Hospital meeting will be on Thursday, April 14th. The program is as follows:

1. Presentation of cases.
2. Demonstration of high liver diets by Miss Nicholls.
3. Disorders of respiration, clinical and experimental studies, by Dr. Carl Binger, of the Rockefeller Hospital Staff, New York City.

Physicians, medical students, nurses, social workers and dieticians are invited to attend.

Joseph C. Aub.

THE ANNUAL MEETING OF THE NEW ENGLAND DERMATOLOGICAL SOCIETY

The annual meeting of the New England Dermatological Society will be held in the Skin Out-Patient Department, Boston City Hospital, on Wednesday, April 13, 1927, at 3 P. M.

Walter T. Garfield, *Secretary.*

SOCIETY MEETINGS

District Medical Societies

Essex North District Medical Society

Wednesday, May 4, 1927—Annual meeting. Russell Hall, Young Men's Christian Association Building, 40 Lawrence Street, Lawrence.

Thursday, May 5, 1927—Censors meet for examination of candidates at Hotel Bartlett, 95 Main Street, Haverhill, at 2 P. M.

Essex South District Medical Society

Thursday, May 5, 1927—Censors meet for examination of candidates at the Salem Hospital, 3:30 P. M.

Wednesday, May 11, 1927—Annual meeting. The Tavern, Gloucester. Speaker and subject to be announced later.

Norfolk District Medical Society

Below are the proposed meetings of the Norfolk District for the remainder of the year. Minor changes may be made in case of necessity.

May 10, 1927—Annual meeting. Details of meeting to be announced.

Suffolk District Medical Society

Meetings of the Suffolk District Medical Society and the Boston Medical Library will be held at the Boston Medical Library, 8 The Fenway, Boston, at 8:15 P. M., as follows:

April 27, 1927—Annual meeting. Election of officers. "Medical Education in the Orient and Occident," Dr. David L. Edsall, Dean, Harvard Medical School.

Notices of meetings must reach the Journal office on the Friday preceding the date of issue in which they are to appear.